Quality Service Review

Protocol for Review of the Status of Infants, Toddlers, and their Families and Performance of Key Service System Functions To Improve their Functioning and Well-being

Version 3.1

Produced for Use by

Iowa's Early ACCESS System (IDEA, Part C)

Iowa Department of Education – Lead Agency
Iowa Department of Human Services
Iowa Department of Public Health
Child Health Specialty Clinics

by Human Systems and Outcomes, Inc.

February 2007

Child's Name	IMS ID#	Early ACCESS Region	Reviewer	Date of Review

Quality Service Review or QSR

The QSR is a method used for appraising the current status of young children and families receiving Early ACCESS services on key indicators and for determining the adequacy of performance of key service system functions for these same persons. The QSR examines outcomes for eligible children and their caregivers and the contribution made by a locally coordinated service system in producing those outcomes. Review results are used for understanding and improving the frontline practices of child-serving agencies.

These working papers, collectively referred to as the QSR Protocol, are used to support a professional appraisal of child and family status and service system performance for individual children and their caregivers in a specific service area and at a given point in time. This protocol is not a measurement instrument designed with psychometric properties intended for research uses and should not be taken to be so. This Iowa QSR Protocol is prepared for and licensed to the Iowa Department of Education. The Iowa contact person for the QSR is Julie Curry, State Coordinator, Early ACCESS (IDEA, Part C), Iowa Department of Education [Phone: 515/281-5437], julie.curry@ed.state.ia.us.

The QSR Protocol and case review methodology are based on a body of work by Ray Foster, PhD and Ivor Groves, PhD of Human Systems and Outcomes, Inc. (HSO). These tools and methods follow a case-based practice review process developed and offered by HSO. Proper use of the QSR Protocol requires reviewer training and supervision. Supplementary materials provided during training are necessary for reviewer use during case review activities. Persons interested in gaining further information about the QSR should contact an HSO representative at:

Human Systems and Outcomes, Inc.

2107 Delta Way

Tallahassee, Florida 32303-4224

Phone: (850) 422-8900
Fax: (850) 422-8487

INTRODUCTION TO THE QUALITY SERVICE REVIEW

TABLE OF CONTENTS

Listed below is the table of contents for this QSR protocol. In addition to these materials, reviewers are provided a set of additional working papers that are used for reference and job aids used for particular tasks (e.g., reviewer agreement checks) conducted during the review.

Note on Rating Status Indicators

Child and Family Status, as measured in these indicators, focuses on the situation observed for the child and family over the past 30 days (one month). The focus is placed on the dominant pattern observed over this time period. In the unlikely event that the pattern has made a significant change within the 30-day period, the most recent status situation should be reflected in the rating.

SECTION 1

CHILD & FAMILY STATUS INDICATORS

Status Review 1: Safety of the Child

SAFETY: • Is the child safe from injury caused by him/herself or others in his/her daily living, learning, and recreational settings? • Are others safe from the child? • Is the child free of abuse, neglect, and sexual exploitation in his/her place of residence?

Scoring Rule: *This indicator applies to the living arrangements and daily settings of the child. If the child is living in the birth home at the time of the review, then the birth home is rated. If the child is having unsupervised visits to the birth home and/or will be returning to the birth home within the next 30 days, the birth home is rated. If the child is not living in the birth home and will not be returning to the birth home, then birth home is rated NA. If the child is presently residing in a foster, kinship, adoptive home, then the substitute home is rated. At least one or more will apply to the focus child. The child care setting is rated unless the child has no structured daytime activity away from home and primary caregiver.*

Child safety is central to child well-being. The child should be free from known and manageable risks of harm in his/her daily settings. Safety from harm extends to freedom from unreasonable intimidations and fears that may be induced by other children, care staff, treatment professionals, or other employees. A child who is unsafe from actual injury or who lives in constant fear of assault, exploitation, humiliation, isolation, or deprivation is at risk of death, disability, mental illness, co-dependent behavior patterns, learning problems, low self-esteem, and perpetrating similar harm on others. Safety and good health provide the foundation for typical child development, especially for children with emotional or behavioral health problems.

Safety applies to settings in the child's natural community as well as to any special care or treatment setting in which the child may be served on a temporary basis. Safety, as used here, refers to adequate management of known risks to the child's physical safety and to the safety of others in the child's daily settings. **Safety is relative to known risks**, not an absolute protection from all possible risks to life or physical well-being. All adult caregivers and professional interveners in the child's life bear a responsibility for maintaining safety for the child and for others who interact with the child. Protection of a child with self-injurious behaviors and protection of others from a child with assaultive behavior may require special safety precautions.

Determine from Informants, Plans, and IFSP Records

Where indicated by family circumstances (e.g. DHS involvement), has there been a completed risk assessment to determine safety risks due to:

- ☐ **1. Domestic violence?**
- ☐ **2. Physical abuse?**
- ☐ **3. Substance abuse?**
- ☐ **4. Sexual abuse?**
- ☐ **5. Emotional abuse?**
- ☐ **6. Mental illness?**
- ☐ **7. Self-endangerment by the child?**
- ☐ **8. Neglect of any physically dependent person in the home?**

If current safety risks require immediate intervention, identify steps taken.

1. Has the child been a victim of abuse, neglect, or exploitation in the home or community?
2. Does the child come from a family that has a history of domestic violence?
3. Does the child have a history of emotional/behavioral problems that have resulted in injury to self or others?
4. Is the child now presenting self-injury or aggression toward others?
5. Has the child exhibited sexual behavior that is developmentally uncharacteristic?
6. Does the child have a pattern of frequent injuries requiring medical treatment?
7. Does the child have a developmental delay or physical disability that requires extraordinary care?
8. Does the child require a high level of adult supervision? Does he/she get it?
9. Are there indications of intimidation or unreasonable fear in the child's life?
10. Does the child have or need an individualized behavior management plan?

Facts Used in Rating Status

Status Review 1: Safety of the Child

Determine from Informants, Plans, and IFSP Records	Facts Used in Rating Status
11. Has the child required special intervention due to behavior problems? 12. Does the child engage in high risk activities? 13. Are any special behavioral interventions or supports required by the child reducing or preventing self-injury or injury to others? 14. Are caregivers aware of risks to the child? Are known risks being managed effectively for the child? 15. Is the child's safety at risk? Are others at risk due to the child's behavior? 16. If the child is in a situation that requires visits between caregivers (e.g., foster care parent, biological parent) is the child's safety at risk at anytime?	

Description and Rating of the Child's Current Status

Description of the Status Situation Observed for the Child	Rating Level
◆ Situation indicates **optimal safety** for all persons in all the child's daily settings. The child has a safe living situation with reliable and competent caregivers, is safe in daily setting and presents no safety risks to self or others. The child is safe from known and manageable risks of harm and is free of unreasonable intimidation or fears at home and daily settings.	**6** ☐ Birth home ☐ Sub. home ☐ Child care
◆ Situation indicates **good safety** for the child in his/her daily settings and for others near the child. The child is generally safe in the facility with adequate caregivers, is usually safe in their daily settings, and presents no or minimal safety risk to self or others. The child is reasonably safe from known and manageable risks of harm and is free of unreasonable intimidation or fears at home and daily settings.	**5** ☐ Birth home ☐ Sub. home ☐ Child care
◆ Situation indicates **fair safety** from imminent risk of physical harm for the child in his/her living and learning settings and for others who interact with the child. The child has a minimally safe living arrangement with the present caregivers, is usually safe in their daily settings, and presents no or minimal safety risk to self or others. The child is minimally safe from known and manageable risks of harm and is minimally exposed to intimidation or fears at home or daily settings.	**4** ☐ Birth home ☐ Sub. home ☐ Child care
◆ Situation indicates **an unacceptable safety issue present in one setting** that poses an elevated risk of physical harm for the child in his/her living and learning settings and for others who interact with the child. The child's living arrangement may require protective supervision or services. The child may mildly injure self or others infrequently. Persons at home or daily settings may pose a safety problem for the child.	**3** ☐ Birth home ☐ Sub. home ☐ Child care
◆ Situation indicates **substantial and continuing safety problems** that pose elevated risks of physical harm for the child in his/her living and learning settings and for others who interact with the child. The child's living arrangements may require protective supervision or specialized services. The child may injure self or others occasionally. Persons at home may pose a serious safety problem for the child.	**2** ☐ Birth home ☐ Sub. home ☐ Child care
◆ Situation indicates **adverse and worsening safety problems** that pose high risks of physical harm for the child in his/her daily settings and for others. The child may require protective supervision or intensive services to prevent injury to self or others. The child may seriously injure self or others. Persons in the child's current daily settings may have abused, neglected, or exploited the child.	**1** ☐ Birth home ☐ Sub. home ☐ Child care
◆ **Not Applicable** for birth home if the child is not living in the birth home and will not be returning to the birth home within 30 days, or does not have unsupervised visit. Substitute home is rated NA if child is living in the brith home. Child care setting is rated NA if the child has no structured daytime activity away from current home and primary caregiver.	**NA** ☐ Birth home ☐ Sub. home ☐ Child care

Status Review 2: Physical Well-Being

PHYSICAL WELL-BEING: • To what degree are the child's basic physical care needs being reliably met on a daily basis?

Scoring Rule: *This indicator applies to the living arrangements and daily settings of the child. If the child is living in the birth home at the time of the review, then the birth home is rated. If the child is having unsupervised visits to the birth home and/or will be returning to the birth home within the next 30 days, the birth home is rated. If the child is not living in the birth home and will not be returning to the birth home, then birth home is rated as NA. If the child is presently residing in a foster, kinship, or adoptive home, then the substitute home is rated. At least one or more will apply to the focus child.*

Infants and toddlers should receive adequate and consistent daily physical care, consistent with their general physical care requirements. Healthy development of children requires that **basic physical needs** for proper nutrition, clothing, shelter, and hygiene are reliably met on a daily basis. Proper **physical care and nutrition** are necessary for maintaining good health. Children who have chronic health conditions requiring special care procedures (e.g., positioning, suctioning, ventilation, tube feeding) should have a level of attention commensurate with that required to maintain physical well-being or, where necessary, improve health status. Special care requirements may also include nursing, physical therapy, adaptive equipment, therapeutic devices, and treatments. Delivery of these physical care services may be necessary in the child's daily settings. The **central concern** here is that the child's physical needs are met and that special care requirements are provided as necessary. Adult caregivers and professional interveners in the child's life bear a responsibility for ensuring that basic physical needs are being met, that environmental conditions in daily settings are hazard-free and sanitary, and that any special care requirements are adequately met on a daily or as needed basis.

Child/Family Status Probes for Review Use

1. Are the child's needs for food, shelter, and physical care being reliably met?

   - ☐ Food and adequate daily nutrition to meet growth requirements.
   - ☐ Hazard-free and sanitary housing and daily care settings.
   - ☐ Body care, including grooming and hygiene.
   - ☐ Clothing appropriate for the season.
   - ☐ Adult supervision to maintain safe and appropriate conditions.

2. Does the family have sufficient income to ensure that basic needs are met?
3. Does the child live in a home under DHS supervision due to neglect of this child or other children in home? Has this child been diagnosed as a "failure-to-thrive?" If so, what strategies and supports are being used to ensure that the basic physical needs of the child are being met on a daily basis?
4. Does the child have a regular sleep schedule? If the child is an infant under 12 months of age, does the infant sleep on the back and play on the tummy?
5. Does the caregiver have and use age-appropriate car restraints for the child?
6. Does the child have any eating problems? If so, is a special diet or feeding procedure required to ensure that the child receives adequate nutrition?
7. Does this child require the use of any special care procedures? If so, who is providing the special care on a daily basis? Has the parent or caregiver been provided with training, support, and supervision on the use of procedures?
8. Does a home visitor monitor this child and caregiver? If so, what is the current status of caregiving in the home according to the home visitor?

Facts Used in Rating Status

Active Prevention of Injury

Physical well-being includes the active prevention of physical injury to a child that may occur in his/her daily settings. This includes prevention of scalding, poisoning, drowning, falling down stairs, being run over in driveways, and injury from other causes that an infant or toddler may experience at home or in child care settings. Child-proofing of kitchens and bathrooms, use of proper child restraint devices including car seats, and close supervision to anticipate and prevent injuries are important aspects of physical care of small children. Active prevention of injury is a fundamental aspect of the physical care of children. Neglect is the failure to provide critical care that may result in harm to a child.

Status Review 2: Physical Well-Being

Description and Rating of the Child's Current Status

Description of the Status Situation Observed for the Child — Rating Level

- Child enjoys **optimal physical care.** All of the child's physical needs for food, shelter, and clothing are fully and reliably met on a daily basis. All of the child's daily settings are excellent in nature and quality, fully sanitary, secure (including car seat restraints), and hazard-free. Any special care requirements are skillfully, fully, and reliably met in the home and other daily settings. All daily caregivers are fully meeting the physical needs of the child.

6
☐ Birth home
☐ Sub. home

- Child receives **substantially good physical care**. The child's physical needs for food, shelter, and clothing are substantially and consistently met on a daily basis. All of the child's daily settings are good in nature and quality, generally sanitary, secure (including car seat restraints), and hazard-free. Any special care requirements are skillfully, substantially, and dependably met in the home and other daily settings. All daily caregivers are dependably meeting the physical needs of the child.

5
☐ Birth home
☐ Sub. home

- Child receives **minimally acceptable to fair physical care**. The child's physical needs for food, shelter, and clothing are being met from a minimally adequate to fair degree on a daily basis. All of the child's daily settings are fair in nature and quality, minimally sanitary, secure (including car seat restraints), and hazard-free. Any special care requirements are being met to a minimally adequate degree in the home and other daily settings. Daily caregivers are minimally meeting the physical needs of the child.

4
☐ Birth home
☐ Sub. home

- Child receives **marginal physical care**. The child's physical needs for food, shelter, hygiene, or clothing may not be consistently met. The child's nutritional or physical status may be somewhat problematic. Some of the child's daily settings may have minor problems in maintaining sanitary, secure (including car seat restraints), and/or hazard-free conditions. Daily caregivers may turn over occasionally, have minor skill or performance limitations, and sometimes be inconsistent in meeting the physical needs of the child.

3
☐ Birth home
☐ Sub. home

- Child receives **poor or unreliable physical care**. The child's physical care needs are chronically or inconsistently unmet resulting in ongoing hygiene, nutrition, or security problems that cause the child to suffer from poor status. Poor physical care may be limiting the child's development and/or reducing the child's ability to perform in their daily settings. Further neglect could lead to physical deterioration, injury, illness, or disability.

2
☐ Birth home
☐ Sub. home

- Child has **serious and worsening physical care problems.** The child's physical care needs are persistently and increasingly unmet resulting in ongoing and worsening physical risks and problems. These problems are causing the child to suffer from poor and declining physical status that is adversely affecting the child's development and/or ability to perform in their daily settings. Further neglect could lead to serious physical deterioration, serious injury, disability, or death.

1
☐ Birth home
☐ Sub. home

- **Not Applicable** for birth home if the child is not living in the birth home and will not be returning to the birth home within 30 days, or does not have unsupervised visit. Substitute home is rated NA if child is living in the birth home at the time of the review.

NA
☐ Birth home
☐ Sub. home

Status Rating 3: Stability

STABILITY: • Are the child's natural settings (e.g., home, child care, and community) stable and free from risk of disruption? • If not, are known risks of disruption being reduced by services provided? [DISRUPTION = an unplanned change in places/persons = INSTABILITY]

Stability in caring relationships and consistency of settings and routines are essential for a child's sense of identity, security, trust, and optimal social development. The caregiver or adult (relative, neighbor, "auntie") who takes time with the child, works through problems of childhood with the child, and models values and life skills is essential for normal development. Building nurturing relationships depends on consistency of contact. For this reason, stability and permanence in the child's living arrangement and social support network form a foundation for child development. A child removed from his/her family home should be living in a safe, appropriate, and permanent home within 12 months of removal with only one interim placement. If this child is in a temporary or unstable situation, prompt actions should be taken to restore the child to a stable situation.

Determine from Informants, Plans, and Service Records

1. Is the child living in a permanent home?
2. Does the child have a history of instability of living arrangements?
3. Are probable causes for disruption of home, child care, early intervention program, or medical care/coverage present?
4. Has the child had a change in child care or medical care/coverage in the past year resulting from his/her removal from home for safety reasons?
5. Has the child had a change in child care, early intervention program, or medical care/coverage in the past year resulting from behavioral problems or psychiatric problems?
6. Has the child required out-of-home treatment for medical or emotional/behavior problems?
7. Has this child's family moved from one residence to another more than once per year since his/her birth?
8. Has this child ever been taken into care by DHS for reasons of child protection?
9. Does this child's family have a stable and adequate income source?
10. Does this child live in a home with an individual who abuses substances?
11. Does this child have a chronic health condition requiring frequent or extended hospitalization?
12. How many out-of-home placements has this child had in the course of his/her lifetime?

Facts Used in Rating Status

*If **NO**, note reasons below and number of placements. How many residential placement changes did this child have in the last 12 months? Number = _____.*

How many of these changes were due to psychiatric symptoms or behavioral problems? Number = _____.

Has the child re-entered foster care within the past 12 months?

If so, was it due to the same reasons that caused earlier child removals?, If so, what were those reasons?

*If **NO**, note reasons below and number of placements. How many educational placement changes did this child have in the last 12 months? Number = _____.*

How many of these changes were due to child welfare related changes in homes and caregivers? Number = _____.

**If the child has been receiving services from Early ACCESS for less than 12 months, then since the start of Early ACCESS involvement.*

Status Rating 3: Stability

Description and Rating of the Child's Current Status

Description of the Status Situation Observed for the Child — Rating Level

- **Optimal Stability**. Child has **optimal stability** in home and daily settings and enjoys positive and enduring relationships with parents/caregivers, key adult supporters, and peers in those settings. Only age-appropriate changes are expected. **6** ☐

- **Good Stability.** Child has **substantial stability** in home and daily settings with no disruptive changes during the past year or since Early ACCESS started services. The child has established positive relationships with parents/caregivers and peers in those settings. Only age-appropriate changes are expected. **5** ☐

- **Fair Stability.** Child has **minimally acceptable to fair stability** in home and daily settings with **two or fewer changes** within the last year. The child has established positive relationships with parents/caregivers and peers in those settings. Adoption/relative placement or age-appropriate changes may be expected in the next year. Stability is minimally adequate given the current level of intervention or supports. **4** ☐

- **Some Inconsistency.** Child has **experienced unplanned changes** in home and/or daily settings with with **two or more changes** within the last year. There is an elevated risk of disruption and the child and current caregiver need added supports and services to maintain stability. Further disruptions could occur within the next year. Causes of disruption are known, but services are not working effectively to resolve the issues causing disruptions. **3** ☐

- **Continuing Instability.** Child has **substantial and continuing problems of stability** in home and/or daily settings with **two or more changes** within the last year. Repeated disruptions have resulted in changes of primary caregivers. Further disruptions are likely to occur within the next year. Causes of disruption are known, but services are not adequately or realistically addressed in current plans or current plans are not being implemented on a timely and competent basis. **2** ☐

- **Worsening Pattern of Instability.** Child has **serious problems and worsening problems of stability** in home and/or daily settings with **three or more changes** within the last year. Repeated disruptions have resulted in many changes of primary caregivers. Further disruptions are likely to occur within the next year. Causes of disruption are complex and are not adequately or realistically addressed and/or current services are not being implemented on a timely and competent basis. **1** ☐

Status Rating 4: Permanency

PERMANENCY: • Is the child living in a home that the child, caregivers, and other stakeholders believe will endure until the child becomes independent? • If not, is a permanency plan presently being implemented on a timely basis that will ensure that the child will live in a safe, appropriate, and permanent home?

Every child is entitled to a safe, secure, appropriate, and permanent home. A home with a family is the permanency priority for all children. A child removed from his/her family home should be living in a safe, appropriate, and permanent home within 12 months of removal with only one interim placement. Concurrent planning should begin immediately when the parents' prognosis for reunification has been assessed and it is deemed unlikely that the child will remain at home or be reunified. Where appropriate, termination of parental rights (TPR) and adoption should be accomplished expeditiously. Permanency is achieved when the child is living in a home that the child, caregivers, and other stakeholders believe will endure until the child becomes independent. Evidence of permanency includes resolution of guardianship, adequate provision of necessary supports for the caregiver, and the achievement of stability in the child's natural settings (e.g., home, child care, community).

Child/Family Status Probes for Review Use

1. Is the child living in a permanent home?

   ☐ Yes *[If YES, answer the following questions:]* ☐ No

   - Is the bio-parent satisfied with this home?
   - Are caregivers capable, supported, and satisfied?
   - Are legal barriers to achieving permanency resolved (e.g. TPR)?

2. Are DHS child protective services now involved with this child?

3. Is the child experiencing frequent informal or formal moves between family members or other caregivers?

4. If the child does not yet live in a permanent home, is a permanency plan in place? If yes, what is the permanency plan's relationship to the IFSP?

5. If this child has unresolved permanency issues, are all members of the child's service team working toward the same permanency goal and plan?

6. For a child in foster care, do frequent visits occur between the birth parents and the child (unless parental rights have been terminated or the child was abandoned)? Do frequent visits occur with siblings?

7. If applicable in this case, do visits occur at a time convenient for the parent? In the least restrictive setting? With supervision, if necessary?

Facts Used in Rating Status

If permanency for this child is unresolved, have all permanency options been explored?

- ☐ *Remain at home*
- ☐ *Reunification*
- ☐ *Kinship home*
- ☐ *Adoption*
- ☐ *Guardianship*

Has a diligent search been conducted to identify relatives of the mother and father who could act as placement resources for this child?

What assessments have been conducted to determine if relatives can provide an appropriate placement for this child?

If the child is living with relatives, will this arrangement become a permanent placement for this child?

Status Rating 4: Permanency

Description and Rating of the Child's Current Status

Description of the Status Situation Observed for the Child — Rating Level

- Child is **achieving permanency. EITHER** The child presently lives with his/her birth family and has no history of disruption nor present circumstances likely to cause disruption of this enduring relationship. **- OR -** The child lives in a home that the child, caregivers, and caseworker are confident will endure until the child becomes independent. All adoption or other legal issues are settled or will be settled within the next 30 days. Examples: Child lives in a foster/adoptive home and is legally free (parental rights have been terminated) and the foster parents have adopted or are in the process of adopting this child; child lives at home with his/her parents or legal guardians; child lives with relatives or other caregivers who have permanent custody and legal guardianship of the child. Permanency and, where applicable, DHS case closure are imminent. **6** ☐

- Child has **a substantially resolved permanency situation.** The child lives in a home that the child, caregivers, and caseworker believe will probably endure until the child becomes independent. Any adoption/legal issues are settled or about to be settled. Permanency and, where applicable, DHS case closure are likely within three months. **5** ☐

- Child has **a minimally resolved permanency situation.** The child lives in a home that the child, caregivers, and caseworker believe could endure until the child becomes independent. Any legal issues are either resolved or in the process of timely resolution. **- OR -** There is a clear, realistic, and achievable permanency plan being implemented and the child, caregivers, and caseworker believe that it will ensure that the child will live in a safe, appropriate, permanent home on a timely basis. Permanency and, where applicable, DHS case closure are possible within six months. **4** ☐

- Child has **an unresolved permanency situation.** The child is living in a home that the child, caregivers, and caseworker believe could endure until the child becomes independent if safety and stability can be achieved, or an adoptive home if adoption/guardianship issues can be settled, or an independent living home if the child finds it satisfactory. **- OR -** The child is living on a temporary basis with a substitute caregiver, but the likelihood of reunification or finding another permanent home remains uncertain. **3** ☐

- Child has **substantial and continuing unresolved permanency issues.** The child is living in a home that the child, caregivers, and caseworker doubt could endure until the child becomes independent, due to safety and stability problems or failure to resolve adoption/guardianship issues, or because the current home is unacceptable to the child. **- OR -** The child remains living on a temporary basis (more than six months) with a substitute caregiver without a clear, realistic, or achievable permanency plan being implemented. **2** ☐

- Child has **serious problems and worsening unresolved permanency issues.** The child is moving from home to home due to safety and stability problems or failure to resolve adoption/guardianship issues or because the current home is unacceptable to the child. **- OR -** The child remains living on a temporary basis (more than 12 months) with a substitute caregiver without a clear, realistic, or achievable permanency plan being implemented. **1** ☐

- **Not Applicable.** The child has no history of permanency issues. **NA** ☐

Status Review 5: Daily Settings

DAILY SETTINGS: Is the child living, learning, and playing in his/her home community? • Are the child's daily settings the most appropriate inclusive settings in which he/she may live, learn, and play with others?

The natural or "home community" for a child usually is the one into which he/she is born. Home community involves one's birth family, culture, village or neighborhood, nearby early learning setting, and natural peer group. A child's home community is the context for his/her family support network and for the child's early learning and care. The home community provides the **daily settings** for a child. These daily settings provide the sources of the child's identity, culture, sense of belonging, and connections with those things that give meaning and purpose to life. **A child's home community with normal daily settings offers the least restrictive and most appropriate, inclusive settings in any routine location in which the child may live, learn, and play.** The focus of this review is placed on the child's daily living, learning, and care settings.

Facts used in rating status refer to Job Aid for Indicators of Quality Caregiving, sections IV and V, see page 77 of this protocol.

Determine from Informants, Plans, and IFSP Records

1. Does the child live with his/her biological parents or extended family?

2. If the child receives services in a setting other than a home, is this the setting closest to the child's residence? Does the distance from home to the other setting place an unreasonable burden on the family?

3. Is the child in the most appropriate, inclusive community setting consistent with the child's culture and peer group? If not, what is the plan to get there?

4. Are services embedded in the family's daily routine and typically occurring community activities?

5. Do supports enhance the child and family/caregiver's ability to participate in home and community life?

Facts Used in Rating Status

Status Review 5: Daily Settings

Description and Rating of the Child's Current Status

Description of the Status Situation Observed for the Child — Rating Level*

- **Optimal Daily Settings**. The child is living in the **most appropriate setting** necessary to meet all of the child's basic and special needs. **Daily settings are optimal** for the child's living, early learning, care, socialization, and integration into the community. The daily settings are an excellent and fully appropriate match for the child. **6** ☐

- **Good Daily Settings.** The child is living in a **generally appropriate setting** necessary to meet all of the child's substantial needs. **Daily settings are substantially consistent** with the child's living, early learning, care, socialization needs, and integration into the community. The daily settings are a good match for the child. **5** ☐

- **Fair Daily Settings.** The child is living in the **minimally adequate to somewhat appropriate setting** necessary to meet the most important needs of the child. **Daily settings are minimally consistent** with the child's living, early learning, care, socialization needs, and integration into the community. The daily settings are a fair match for the child. **4** ☐

- **Marginal Daily Settings.** The child is **living in a marginally appropriate setting** necessary to meet his/her needs. **Daily settings are somewhat limited or inconsistent** with the child's living, early learning, care, socialization needs, and integration into the community. Either the **level of care is slightly lower than necessary** to meet needs or the **degree of restriction is slightly higher than necessary** for this child. The daily settings are a somewhat limited or inconsistent match for this child. **3** ☐

- **Poor Daily Settings.** The child is living in a **substantially inadequate setting** that is unable to meet his/her needs. **Daily settings are not consistent** with the child's living, early learning, care, socialization needs, and integration into the community. The daily settings are **substantially more restrictive or less supportive** than necessary to meet his/her needs. The daily settings are a poor, inadequate match for this child. **2** ☐

- **Adverse Daily Settings.** The child is living in an **inappropriate setting** that is unable to meet his/her needs. **Daily settings have an adverse effect** on the child's living, early learning, care, socialization needs, and integration into the community. The child's daily settings are **much more restrictive than necessary or offer a level of care that is insufficient to meet critical needs.** The daily settings are not only adverse but are contributing to a worsening situation for the child. **1** ☐

Status Review 6: Development

DEVELOPMENT: • Is the child's developmental status commensurate with his/her age and ability based on the child's condition? • If not, what is the child's current developmental status of key functional skills?

Each child is expected to be a learner who is actively engaged in developmental activities consistent with age and level of functioning. Developmental status, as used here, is concerned not only with developmental progress as indicated by the acquisition and demonstration of functional capabilities in major life areas that are consistent with age and abilities. **Essential functional capabilities** include: physical (movement/mobility), vision, hearing, communication, social/emotional (socialization), adaptive (self-help, self-regulation), cognitive (learning/pre-literacy skills), and health. The **ultimate concern** is whether the child's learning is consistent with normal developmental milestones or with a plan of skill development set forth in the IFSP that is consistent with the child's abilities and level of functioning. Children of normal ability should be achieving the developmental milestones and acquiring the pre-literacy skills listed in *Indicators of Typical Development Ages 1-3 Years*, a working paper accompanying this protocol. Children with developmental delays who are not achieving developmental milestones and pre-literacy skills at expected ages should be actively involved in developmental education programs that will maximize their ability to later succeed in school and participate fully in home and community life. Supports for living, learning, and socialization may be required for some children who have limitations due to conditions/delays both during early childhood and later in their lives.

Determine from Informants, Plans, and Service Records

1. Is the child physically present to receive services on a regular basis, consistent with needed levels of intensity to advance skill development?

2. If not, is the child frequently sick or not available?

3. What is this child's current essential functioning level as measured by assessments of key developmental milestones? To what degree is developmental status showing delays and in which key areas of functioning?

4. Does this child have an IFSP for developing functional skills in those areas in which development is presently delayed?

5. Does the child actively participate in services/activities consistent with his/her age and developmental skill level? If so, how or how not?

6. Is the child achieving key developmental milestones at or above age-appropriate levels or as described on the IFSP?
   - Physical
   - Vision
   - Hearing
   - Communication
   - Social/emotional
   - Adaptive
   - Cognitive
   - Health

7. Are any necessary supports for the child and family (e.g., sign language training, assistive technology, mobility aids) being provided?

8. Does this child/family require other intervention services to progress toward age-appropriate developmental skills? If so, what interventions are needed?

9. Is this child/family receiving other related services (i.e.,year round services), if recommended?

Facts Used in Rating Status

NOTE:

Key functional areas for skill development include:

- *Physical (movement/mobility)*
- *Vision*
- *Hearing*
- *Communication*
- *Social/emotional (socialization)*
- *Adaptive (self-help, self-regulation)*
- *Cognitive (learning/pre-literacy skills)*
- *Health*

Status Review 6: Development

Description and Rating of the Child's Current Status

Description of the Status Situation Observed for the Child — Rating Level

- **Optimal Developmental Status**. **EITHER** The child's current developmental status is **at or above age expectation** in all major functional areas, based on normal developmental milestones. **- OR -** The child's current developmental status is at or above expected levels set forth in an individualized plan of skill development in the IFSP or related therapeutic plans. **6** ☐

- **Good Developmental Status. EITHER** The child's current developmental status is **at age expectation** in many major functional areas, based on normal developmental milestones. **- OR -** The child's current developmental status is at expected levels set forth in an individualized plan of skill development in the IFSP or related therapeutic plans. **5** ☐

- **Fair Developmental Status. EITHER** The child's current developmental status is **near age expectation** in major functional areas, based on normal developmental milestones. Delays are no more that 10% below expectation in any major functional area. **- OR -** The child's current developmental status is near expected levels set forth in key functional areas in an individualized plan of skill development in the IFSP or related therapeutic plans. **4** ☐

- **Marginal Developmental Status. EITHER** The child's current developmental status is **mixed, somewhat near expectation** in some functional areas and below in others, based on normal developmental milestones. Delays are no more that 20% below expectation in any major functional area. **- OR -** The child's current developmental status is mixed or somewhat inconsistent expected levels set forth in key functional areas in an individualized plan of skill development in the IFSP or related therapeutic plans. **3** ☐

- **Poor Developmental Status. EITHER** The child's current developmental status is **below expectation** in key functional areas and inconsistent in others, based on normal developmental milestones. Delays are more that 30% below expectation in some major functional areas. **- OR -** The child's current developmental status is below expected levels set forth in key functional areas in an individualized plan of skill development in the IFSP or related therapeutic plans. **2** ☐

- **Adverse Developmental Status. EITHER** The child's current developmental status is **far below expectation** in key functional areas and shows a pattern of decline or regression in one or more key functional areas. Delays are more that 50% below expectation in some major functional areas. **- OR -** The child's current developmental status is far below expected levels set forth in key functional areas in an individualized plan of skill development in the IFSP or related therapeutic plans with evidence of regression present in some key areas. **1** ☐

Status Review 7: Health

HEALTH: • Is the child in good health? • Are the child's basic and special health care needs being met? • Does the child have medical health care services, as needed?

Children should achieve and maintain good health status, consistent with their general physical condition. Healthy development of children requires that **basic physical needs** for proper nutrition, clothing, shelter, and hygiene are met on a daily basis. Proper **medical and dental care** (preventive, acute, chronic) are necessary for maintaining good health. Preventive health care should include immunizations, dental hygiene, and screening for possible physical or developmental problems. Physical well-being encompasses both the child's physical health status and access to timely health services. Delivery of these services may be necessary in the child's daily settings including therapeutic programs, preschool/child care, and home.

Children who have chronic health conditions requiring special care or treatment should have a level of attention commensurate with that required to maintain and improve health status. Special care requirements may include nursing, physical therapy, adaptive equipment, therapeutic devices, and treatments (e.g., medications, suctioning).

The **central concern** here is that the child's physical needs are met and that special care requirements are provided as necessary to achieve optimal health status. Adult caregivers and professional interveners in the child's life bear a responsibility for ensuring that basic physical needs are being met and that health risks, chronic health conditions, and acute illnesses are adequately addressed in a timely manner including access to medical/health care for special needs.

Determine from Informants, Plans, and IFSP Records

1. Is the child in good physical health?
2. Is the child underweight or overweight?
3. Does the child have frequent colds, infections, or injuries?
4. Does the child have a history of major recurrent health problems?
5. Does the child have a medical home? (see definition)
6. Does the child have regular medical checkups and screenings at the intervals recommended by the American Academy of Pediatrics: one week of age, 1, 2, 4, 6, 9, 12, 15, 18, 24, and 36 months?
7. Does the child have annual dental checkups and acute dental care as needed and as recommended by the American Dental Society?
8. Are all of the child's immunizations up to date?
9. Does the child have prompt access to acute care when needed?
10. Does the child have 24 hour/7 days a week access to care and treatment of chronic medical conditions, if needed?
11. If the child requires special care or treatment for a health condition, are the required services and equipment provided in the home, preschool/child care/early intervention program, as needed by the child?
12. If the child has a chronic health condition, is the child's health care provider a part of the child's service team?

*A **medical home** is not a building, house, or hospital, but rather an approach to providing health care services in a high-quality and cost-effective manner. Children and their families who have a medical home receive the care that they need from a pediatric health care professional whom they trust. The pediatric health care professional and parents act as partners in a medical home to identify and access all the medical and non-medical services needed to help children and their families achieve their maximum potential.*

Accessible
- *Care is provided in the child's community*
- *All insurances, including Medicaid, is accepted and changes are accommodated*

Family-Centered
- *Recognition that the family is the principle caregiver and the center of strength and support for the children*
- *Unbiased and complete information is shared on an ongoing basis*

Continuous
- *Same primary pediatric health care professionals are available from infancy through adolescence*
- *Assistance with transitions (to school, home, adult services) is provided*

Comprehensive
- *Health care is available 24 hours a day, 7 days a week*
- *Preventive, primary, and tertiary care needs are addressed*

Coordinated
- *Families are linked to support, educational, and community-based services*
- *Information is centralized*

Compassionate
- *Concern for well-being of the child and family is expressed and demonstrated*

Culturally Effective
- *Family's cultural background is recognized, valued, and respected*

—American Academy of Pediatrics

Status Review 7: Health

Determine from Informants, Plans, and IFSP Records	Facts Used in Rating Status
13. Does the child have a health condition requiring monitoring by a qualified provider? If so, is timely and adequate monitoring provided as indicated?	
14. If the child takes medications for chronic health problems, seizures, or behavior control, are medications monitored for safety and effectiveness at least quarterly by the prescribing physician?	
15. Does the child reside in a treatment facility or specialized care home?	
16. Is a qualified health professional involved in obtaining and analyzing health information?	

Description and Rating of the Child's Current Status

Description of the Status Situation Observed for the Child — Rating Level

- The child enjoys **optimal health status.** Routine preventive medical (e.g., immunizations, check-ups, and developmental screening) and dental care are provided on a timely basis. Any acute or chronic health care needs are met on a timely and adequate basis, including necessary follow-ups and required treatments. The child's height and weight are appropriate for the child's health and developmental status. The child rarely has colds, infections, or injuries. **6** ☐

- The child is in **substantially good health**. Routine health and dental care are generally provided but not always on schedule. Acute or chronic health care is generally adequate, but follow-ups or required treatments may be missed or delayed occasionally. Height and weight are appropriate for the child's health and developmental status. The child may have occasional colds, infections, or non-suspicious minor injuries that respond quickly to treatment. **5** ☐

- The child has **minimally acceptable to fair health status.** Routine health and dental care are minimally provided but not always on schedule. Some immunizations may not have occurred. Acute or chronic health care is generally adequate, but follow-ups or required treatments may be missed or delayed but are not life threatening. Height and weight are appropriate for the child's health and developmental status. The child may have frequent colds, infections, or non-suspicious minor injuries that respond adequately to treatment. **4** ☐

- The child has **health care needs that are not adequately met.** The child's nutritional or physical status is problematic. Routine health and dental care may not be adequately provided. Immunizations may not have occurred. Acute or chronic health care may be inadequate and/or follow-ups or required treatments may be missed or delayed but are not immediately life threatening. The child may be underweight or overweight. The child may have frequent colds, infections, or suspicious minor injuries. **3** ☐

- The child has **substantial and continuing health care needs that are unmet.** The child's nutritional or health care needs are chronically or consistently unmet, resulting in ongoing health problems that cause the child to suffer from poor health status that is affecting the child's development and/or ability to perform age-appropriate tasks or activities. Further neglect of health-related problems could lead to physical deterioration or disability. **2** ☐

- The child has **serious and worsening health care problems.** The child's nutritional or health care needs are unmet, resulting in ongoing and worsening health problems. These problems are causing the child to suffer from poor and declining health status that is adversely affecting the child's development. Further neglect could lead to serious physical deterioration, disability, or death. **1** ☐

Status Review 8: Social/Emotional/Behavioral

SOCIAL/EMOTIONAL/BEHAVIORAL: • To what degree does the child present patterns of emotion and social behavior consistent with typical child development? • Is the child free of emotional or behavioral symptoms that interfere with his/her capacity to participate in and benefit from daily routines and learning opportunities at home, in child care, and in the community?

Young children should grow, develop, and learn in ways that result in social/emotional health. As a child progresses, he/she becomes interested in immediate surroundings, develops a sense of self, trusts caregivers, interacts with caregivers, learns to separate from caregivers, learns ways to show emotions (cooing, giggling, crying, temper tantrums), watches other children play from a distance, imitates others, plays with other children, expresses desires, shares and takes turns, develops respect for others and and feelings of empathy, and experiences emotional closeness, attachment, and bonding. He/she picks up affective cues from caregivers that builds awareness of nonverbal cues in others necessary to develop social abilities. The child's social support settings helps to shape trust, attachment, and temperament.

Infants and toddlers who may present early indications of emotional problems may: have problems calming down or self-regulating, be extremely distractable, not be able to build or maintain a satisfactory relationship, have a poor attention span, cry excessively, self-stimulate with stereotypic movements, have a mood that is generally unhappy or depressed, be upset or confused by sounds or movements, avoid being touched by others, be overly anxious or fearful of others, or have disordered sleeping patterns. These behaviors may interfere with learning and socialization. Young children who have disabling conditions or who have experienced trauma, neglect, or life disruptions may present early indications of emotional/behavioral problems that may later be diagnosed and treated. Early intervention efforts begin with screening for early indications and risk factors and responding with appropriate supports and training for caregivers.

Determine from Informants, Plans, and Service Records

1. Is this child following typical patterns of emotional and social development consistent with his/her developmental level or condition?

2. Does this child present any known risk factors for social/emotional or behavioral problems? Has this child experienced trauma, neglect, or disrupted/inadequate attachments? Does the child have a behavior problem that interferes with daily activities?

3. Does the child generally present an affect appropriate to demands and opportunities of the situation (e.g., appropriate fear of aggressive animals and interest in new toys, enjoyment of familiar play routines and caregiver affection)?

4. Does the child generally appear happy or content?

5. Does the child participate in age-appropriate group activities?

6. Does the child show preferences (which may be transient and inconsistent) for certain activities, people, and objects? Does the child discriminate between familiar individuals and strangers?

7. Is the child securely attached to at least one primary caregiver (i.e., goes to this caregiver for comfort, is upset when caregiver leaves, happy when she/he returns, seeks physical contact with this caregiver, but in a familiar situation, child can move away from caregiver to explore a new toy or play with another child)?

8. Are known emotional/behavioral risks (e.g., domestic violence) being managed effectively for the child at home, at the program, and in the community?

Facts Used in Rating Status

Status Review 8: Social/Emotional/Behavioral

Description and Rating of the Child's Current Status

Description of the Status Situation Observed for the Child — Rating Level

- **Optimal social/emotional status**. The child presents **optimal patterns of social/emotional and social behavior** consistent with normal child development or with patterns consistent with this child's developmental level of their condition/disability. The child has excellent, secure attachments with one or more caregivers. The child is fully free of emotional or behavioral symptoms that interfere with his/her capacity to participate in and benefit from daily routines and learning opportunities at home, in child care, and in the community. **6** ☐

- **Good social/emotional status**. The child presents **substantially good patterns of social/emotional and social behavior** generally consistent with normal child development or with patterns expected for this child's developmental level of their condition/disability. The child has a good and secure attachment with one or more caregivers. The child is mostly free of emotional or behavioral symptoms that interfere with his/her capacity to participate in and benefit from daily routines and learning opportunities at home, in child care, and in the community. Any symptoms are only mildly inappropriate for a child of this age, are brief and infrequent with a good pattern of improvement. **5** ☐

- **Fair social/emotional status**. The child shows **minimally acceptable patterns of social/emotional and social behavior** somewhat consistent with normal child development or with patterns expected for this child's developmental level of their condition/disability. The child has a secure attachment with one primary caregiver. The child has some mild problems functioning at an age-appropriate or expected level in daily settings. Any symptoms are somewhat inappropriate for a child of this age, are regular but usually brief with a fair pattern of improvement. **4** ☐

- **Marginal social/emotional status**. The child shows **marginal patterns of social/emotional and social behavior** somewhat inconsistent with normal child development or with patterns expected for this child's developmental level of their condition/disability. The child has a marginally adequate attachment relationship with at least one caregiver. The child has mild-to-moderate emotional and behavioral problems that adversely affect functioning in daily activities. Symptoms are somewhat problematic and do not seem to be improving. **3** ☐

- **Poor social/emotional status**. The child has **substantial and continuing problems of social/emotional and social behavior** quite divergent from normal child development or from patterns expected for this child's developmental level of their condition/disability. The child may have persistently negative interactions with, or avoids, family members, caregivers, and other children. The child has no securely attached relationship. The child has moderate-to-serious emotional and/or behavioral problems in daily settings. Symptoms are not improving. The child's emotional/behavioral condition may threaten his/her ability to remain in the current preschool/child care setting. **2** ☐

- **Adverse social/emotional status**. The child has **serious and worsening problems of social/emotional well-being** at home and in other settings. Serious emotional and/or behavioral problems limit functioning and may cause restriction in program or community settings. The child's emotional/behavioral condition is worsening and threatens the child's ability to learn and develop in other domains. The child may have been removed from a recent preschool/child care setting. **1** ☐

Status Review 9: Parenting/Caregiving

PARENTING/CAREGIVING: Are the child's primary caregivers in the home and/or child care settings supporting the development of the child adequately on a consistent daily basis?

Scoring Rule: *This indicator may be rated for a foster, kinship, or adoptive home where the child may live and/or for a parent home where the child may live or have unsupervised visits. Thus, this indicator may be applied to either or both birth parent and substitute caregiver.*

It is well established that appropriate child growth and development will not occur in isolation from the family. Therefore the importance of enhancing the capacity of families to meet the special needs of their infant and toddler will be reflected in Early ACCESS services. These services are provided in natural settings to support each family's ability to meet their children's everyday needs. Additionally, Iowa has a high percentage of young children whose parents work outside of the home, thus families of young children in Iowa have a high need for quality, nurturing child care settings. Providers of child care also need support in meeting the typical and unique needs of a child eligible for Early ACCESS services.

Caregiver in this context means whoever has primary responsibility for the child during the child's days/weeks, including parents, extended family members, child care providers, foster care parents, and guardians. The primary focus in this exam is on parent/primary caregiver-provided supports necessary for the child to learn, participate in family activities, and benefit from services and programs.

Facts used in rating status refer to Job Aid for Indicators of Quality Caregiving, sections I, II and III, see page 82 of this protocol.

Determine from Informants, Plans, and Service Records	Facts Used in Rating Status
1. Has the family been empowered to access and use resources needed for their child and family?	
2. Are there activities/tasks performed by the family to support early intervention services manageable and integrated into their daily activities?	
3. If needed, is the family able to find safe, affordable, accessible child care?	
4. Have services been offered to all caregivers who have primary responsibility for the child during the day/week (family, child care provider, extended family)?	
5. If needed, does the child care arrangement meet the needs for the child and family? Are they likely to be able to continue in this setting?	
6. Has the family had to change child care arrangements due to the special needs of the child?	
7. Does the child care setting have what it needs to support the child's health and development?	
8. How confident do caregivers feel in meeting the child's needs? Are they more confident as a result of interaction with Early ACCESS?	
9. Do caregivers (including the family) report increased knowledge, skill and confidence in meeting the needs of the child as a result of interaction with Early ACCESS?	

Status Review 9: Parenting/Caregiving

Description and Rating of the Child's Current Status

Description of the Status of the Child and His/Her Parent/Caregiver Support — Rating Level

- **The child is receiving optimal parent/caregiver support.** The child has a regular schedule of meals, naps, bedtime, and other activities. The child always participates in programs and services as planned, appropriately dressed and fed, and with needed supplies. The child participates fully in the life of the family at home and in the community. The child is benefitting from programs and services as shown through timely achievement of all developmental milestones consistent with abilities. The child's basic and special needs are consistently met. The child is regularly read to, talked to, listened to, and played with by primary caregivers.

  6
  ☐ Birth parent
  ☐ Sub. c'giver

- **The child is receiving substantially adequate parent/caregiver support.** The child generally has a regular schedule. The child usually participates in programs and services as planned, appropriately dressed and fed, and with needed supplies. The child usually participates in the life of the family. The child is benefitting from programs and services as shown through timely achievement of most developmental milestones consistent with his/her ability levels. The child's basic and special needs are generally met. The child is often read to, talked to, listened to, and played with by primary caregivers.

  5
  ☐ Birth parent
  ☐ Sub. c'giver

- **The child is receiving minimally adequate to fair parent/caregiver support.** Some elements of the child's day are generally predictable. The child usually participates in programs and services, though less than planned, is usually appropriately dressed and fed, and may have needed supplies. The child occasionally participates in the life of the family. The child's basic and special needs are minimally met or inconsistently met. The child is minimally read to, talked to, listened to, and played with by primary caregivers.

  4
  ☐ Birth parent
  ☐ Sub. c'giver

- **The child has some unmet parent/caregiver support needs.** The child has a fairly unpredictable schedule. The child seldom participates in programs and services, is often not appropriately dressed or fed and does not have needed supplies. The child participates a little but not at an age- and ability-appropriate level, in the life of the family. The child's basic and special needs are inconsistently met. The child is inconsistently read to, talked to, listened to, and played with by primary caregivers.

  3
  ☐ Birth parent
  ☐ Sub. c'giver

- **The child has substantial unmet parent/caregiver support needs.** The child has no consistent schedule. The caregiver may be unable to meet the caregiving demands for periods of time. Basic care of children, supervision, and assistance may be interrupted. Moderate risks may be present.

  2
  ☐ Birth parent
  ☐ Sub. c'giver

- **The child has extensive unmet parent/caregiver support needs.** The child has no consistent schedule. The child does not participate in planned programs and services. The caregiver may be frequently absent or unable to perform parenting responsibilities for extended periods of time. Basic care of children, supervision, and assistance may be often interrupted. High risks may be present.

  1
  ☐ Birth parent
  ☐ Sub. c'giver

- **Not Applicable** for birth parent if the child is not living in the birth home and will not be returning to the birth home within 30 days, or does not have unsupervised visit. Substitute caregiver is rated NA if child is living in the birth home at the time of the review.

  NA
  ☐ Birth parent
  ☐ Sub. c'giver

Status Review 10: Parental Participation in Decisions

PARENTAL PARTICIPATION IN DECISIONS: • Are the child's parents ongoing participants in decisions made about the child's early intervention plans, services, and results? • If not, are continuing efforts being made to accommodate or assist parent participation or to provide a competent and well-prepared surrogate parent as an advocate?

Scoring Rule: *This indicator may be rated for a foster, kinship, or adoptive home where the child may live and/or for a parent home where the child may live or have unsupervised visits. Thus, this indicator may be applied to either or both parent and substitute caregiver.*

As the child's first and foremost teacher and as the child's legal and primary advocate, and an able, active, and ongoing partner in the child's development, the parent supports the child by:

- Assisting with the child's development by ensuring daily intervention and follow-through on IFSP outcomes and activities.
- Planning IFSP outcomes, activities, and services.
- Following through with early learning and care providers to ensure consistency of IFSP implementation and coordination.
- Encouraging and supporting the child's participation in developmentally appropriate activities in the community.

To fulfill the role of child advocate and supporter, the parent will be engaged as a service partner in assessing needs, making plans, implementing and monitoring services, and evaluating results and outcomes. In some cases, parents may experience circumstances that reduce their ability or opportunity to participate as a major partner. Working single parents may lose income if required to attend meetings during business hours. Parents with extraordinary caregiver demands in the home or other parents with special needs of their own may have difficulty participating without special accommodations or support. The program has an obligation to engage the parent as a partner in decision making, to make accommodations and provide supports where necessary to facilitate parent participation, or to provide a capable and willing surrogate parent when parents are unable to fulfill this critical role. The surrogate should come prepared to participate in decisions made on behalf of the child. This means knowing the child, visiting with the caregivers, and knowing the situation.

Determine from Informants, Plans, and Service Records

1. If the child is in foster care, what is the parent's legal status in all aspects of decision-making?
2. Were any parental requests for training or workshop attendance denied due to lack of funds?
3. Does the parent report a variety of service-related options were presented and discussed?
4. Is the parent listened to during all aspects of decision-making?
5. Do the child's parents encourage and support their child in participating in developmentally appropriate community-based activities on a regular basis?
6. Do the child's parents/surrogate parent attend, IFSP meetings, and other activities related to the needs and progress of the child?
7. Are there any factors that substantially and repeatedly prevent or reduce the parent's opportunity or ability to function as an advocate for the child in matters related to the IFSP or to the child's situation and developmental patterns? If so, what are these factors?
8. If there are factors that substantially and repeatedly prevent or reduce the parent's opportunity or ability to function effectively in matters related to the IFSP have special accommodations or supports (native language or mode of communication, transportation, child care, etc.) been offered to the parent to facilitate effective participation? If so, have they been accepted by the parent and has this improved participation? If accommodations or supports have not been offered, why not? What is the parent's satisfaction with the accommodation(s)?

Facts Used in Rating Status

Note:

Parent, as defined in Iowa Administrative Rules 281 - 120.4 Definitions.

"Parent" means:

1. *A biological or adoptive parent of a child;*
2. *A guardian, but not the state if the child is a ward of the state;*
3. *A person acting in the place of a parent, such as a grandparent or stepparent with whom a child lives, or a person who is legally responsible for the child's welfare;*
4. *A surrogate parent who has been assigned in accordance with rule 281 - 120.68; or,*
5. *A foster parent, if:*
   - *A biological parent's authority to make the decision required of parents under state law has been terminated; and*
   - *The foster parent has an ongoing, long-term parental relationship with the child; is willing to make the decisions required of parents; and has no interest that would conflict with the interests of the child.*

Status Review 10: Parental Participation in Decisions

Determine from Informants, Plans, and Service Records	Facts Used in Rating Status
9. If the parent is unable to function as an effective partner, has a surrogate parent been assigned? If not, why not? If so, is this person functioning as a knowledgeable and prepared advocate for the child? 10. If the child is transitioning out of Early ACCESS, does the parent report satisfactory involvement in transition decision-making and planning?	

Description and Rating of the Parent's Current Status

Description of the Status of Parent Participation and Advocacy for the Child — Rating Level

- **Optimal parent participation.** The child's parent, with accommodations or supports if needed, is a **full and effective partner** in all aspects of IFSP-related assessment, service planning, implementation and monitoring, and evaluation of results.

  6
  ☐ Birth parent
  ☐ Sub. c'giver

- **Good parent participation.** The child's parent, with accommodations or supports if needed, is a **substantial and contributing partner** in most aspects of IFSP-related assessment, service planning, implementation and monitoring, and evaluation of results.

  5
  ☐ Birth parent
  ☐ Sub. c'giver

- **Fair parent participation.** The child's parent, with accommodations or supports if needed, is a **participant** in some aspects of IFSP-related assessment, service planning, implementation and monitoring, and evaluation of results.

  4
  ☐ Birth parent
  ☐ Sub. c'giver

- **Marginal parent participation.** The child's parent is an **occasional participant** in a few aspects of IFSP-related assessment, service planning, implementation and monitoring, and evaluation of results. The parent may have limiting circumstances, may not have been offered and/or received accommodations or supports, or may not wish greater participation even with offered accommodations or assistance.

  3
  ☐ Birth parent
  ☐ Sub. c'giver

- **Poor parent participation.** The child's parent **seldom participates** in any aspects of IFSP-related assessment, service planning, implementation and monitoring, and evaluation of results. The parent may have limiting circumstances, may not have been offered and/or received acceptable accommodations or supports, or may not wish greater participation even with offered accommodations or assistance.

  2
  ☐ Birth parent
  ☐ Sub. c'giver

- **No parent participation or advocacy.** The child's parent **has not participated** in any aspects of IFSP-related assessment, service planning, implementation and monitoring, and evaluation of results within the past 12 months. The child may be receiving services in a hospital or special care home, or may have become temporarily "lost" from the early intervention program. The child may have been removed from the family home by child protective services and placed in a foster home, resulting in ambiguity surrounding parental responsibilities for advocacy. **- OR -** The child presently lacks effective adult advocacy and may be adversely affected by a lack of needed services and loss of health and developmental opportunities in his/her present situation.

  1
  ☐ Birth parent
  ☐ Sub. c'giver

- **Not Applicable** for birth parent if the child is not living in the birth home and will not be returning to the birth home within 30 days, or does not have unsupervised visit. Substitute caregiver is rated NA if child is living in the birth home at the time of the review.

  NA
  ☐ Birth parent
  ☐ Sub. c'giver

Status Review 11: Parent Satisfaction

SATISFACTION: Are the parents satisfied with the supports and services they presently are receiving?

Scoring Rule: *This indicator may be rated for a foster, kinship, or adoptive home where the child may live and/or for a birth parent when the child may live in the birth home or have unsupervised visits. Thus, this indicator may be applied to either or both birth parent and substitute caregiver.*

Satisfaction includes the views of the child's parent(s) *(see note defining "parent") . If the child lives with his/her parents, relative, foster parent, then that person's views are solicited. If the child is being served temporarily in a hospital and will be returning home, then the views of the caregiver to whom the child will be returned are solicited. Parent satisfaction is concerned with the degree to which the person receiving services believes that those services are appropriate for their needs, respectful of their views and privacy, convenient to receive, tolerable (if imposed by court order), pleasing (if voluntarily chosen), and ultimately beneficial in effect. Satisfaction extends to:

- Level of **Participation** in decisions and plans made for the benefit of the child and his/her caregiver.
- Feelings of **respect** for their views and preferences in the planning and delivery of services.
- Belief that a **good mix and match** of supports and services is offered that well fits their situation.
- Appreciation for the **quality/dependability** of assistance and support provided.
- Feelings that circumstances are better now than before or are **getting better** because of the supports and services.

Parent should be generally satisfied with services, taking into account that services may not always be voluntary.

Determine from Informants, Plans, and Service Records

1. Does the child now reside with his/her parent or a permanent caregiver?
2. Is the child living at home under protective services supervision?
3. Does the child receive services from several different agencies/programs? If so, does the parent agree that the services and their respective plans and schedules are sufficiently coordinated?
4. Are any of the current services required by a court plan?
5. Does the parent agree that service providers solicit and listen respectfully to his/her opinions and suggestions?
6. Does the parent understand the results of assessments?
7. Does the parent agree with the purpose and type of services received?
8. Does the parent believe that services reflect his/her views?
9. Do services received really match the needs of the child/family?
10. Are services provided at convenient times and places?
11. Does the parent agree that early intervention providers are helping him/her become an informed advocate for this child?
12. Does the parent believe services and supports were received in a timely manner?
13. Does the parent believe that the child is benefiting from these services?
14. Does the parent believe that he/she is benefiting from these services?

Facts Used in Rating Status

** Parent, as defined in Iowa Administrative Rules 281 - 120.4 Definitions.*

"Parent" means:

1. *A biological or adoptive parent of a child;*
2. *A guardian, but not the state if the child is a ward of the state;*
3. *A person acting in the place of a parent, such as a grandparent or stepparent with whom a child lives, or a person who is legally responsible for the child's welfare;*
4. *A surrogate parent who has been assigned in accordance with rule 281 - 120.68; or,*
5. *A foster parent, if:*
   - *A biological parent's authority to make the decision required of parents under state law has been terminated; and*
   - *The foster parent has an ongoing, long-term parental relationship with the child; is willing to make the decisions required of parents; and has no interest that would conflict with the interests of the child.*

Status Review 11: Parent Satisfaction

Determine from Informants, Plans, and Service Records	Facts Used in Rating Status
15. If the child lives in a foster home, does the foster parent feel adequately supported in serving this child? 16. Does the parent believe that the current services will lead to achievement of the IFSP outcomes? 17. If child has exited Early ACCESS, does parent report adequate support during and after transition?	

Description and Rating of Current Status

Description of the Status Situation Observed for the Child and Parent — Rating Level

- The respondent reports **optimal satisfaction** with current supports and services. The quality, fit, dependability, and results being achieved presently exceed a high level of consumer expectation. The respondent "couldn't be more pleased" with the service situation and his/her recent experiences and interactions with service provider.

  6
  ☐ Birth parent
  ☐ Sub. c'giver

- The respondent reports **substantial satisfaction** with current supports and services. The quality, fit, dependability, and results being achieved generally meet a moderate level of consumer expectation. The respondent is "generally satisfied" with the service situation and his/her recent experiences and interactions with service provider. Complaints and disappointments are minimal.

  5
  ☐ Birth parent
  ☐ Sub. c'giver

- The respondent reports **minimal satisfaction** with current supports and services. The quality, fit, dependability, and results being achieved minimally meet a low-to-moderate level of consumer expectation. The respondent is "more satisfied than disappointed" with the service situation and his/her recent experiences and interactions with service provider. Complaints and disappointments are present and continuing.

  4
  ☐ Birth parent
  ☐ Sub. c'giver

- The respondent reports **mild dissatisfaction** with current supports and services. The quality, fit, dependability, and results being achieved do not minimally meet a low-to-moderate level of consumer expectation. The respondent is "more disappointed than satisfied" with the service situation and his/her recent experiences and interactions with service provider. Complaints and disappointments are recent.

  3
  ☐ Birth parent
  ☐ Sub. c'giver

- The respondent reports **moderate and continuing dissatisfaction** with current supports and services. The quality, fit, dependability, and results being achieved do not meet a low-to-moderate level of consumer expectation. The respondent is "consistently disappointed" with the service situation and his/her recent experiences and interactions with service provider. Complaints and disappointments are present and continuing over time.

  2
  ☐ Birth parent
  ☐ Sub. c'giver

- The respondent reports **substantial and growing dissatisfaction** with current supports and services. The quality, fit, dependability, and results being achieved fail to meet any reasonable level of consumer expectation. The respondent is "greatly and increasingly disappointed" with the service situation and his/her recent experiences and interactions with service provider. Complaints and disappointments are long-standing and increasing in their scope and intensity.

  1
  ☐ Birth parent
  ☐ Sub. c'giver

- **Not Applicable** for birth parent if the child is not living in the birth home and will not be returning to the birth home within 30 days, or does not have unsupervised visit. Substitute caregiver is rated NA if child is living in the birth home at the time of the review.

  NA
  ☐ Birth parent
  ☐ Sub. c'giver

SHIFTING FROM CHILD AND FAMILY STATUS INDICATORS TO PROGRESS INDICATORS

NOTE:

The focus of the QSR review now shifts from the PRESENT STATUS of the child and family (over the past 30 days) to RECENT PROGRESS or changes observed for the child and family (over the past six months or since admission, if less than six months).

Child and family status indicators 1-11 focused on the PRESENT STATUS of the child or family as observed over the past 30 days. The next four progress indicators focus on the degree to which change has occurred from baseline measures or interim measures taken six months ago to the time of review. The reviewer should rely on assessments, goals, and progress notes in the case record and on information gained from key informants in rating child and family progress on the following indicators of RECENT PROGRESS.

SECTION 2

RECENT PROGRESS

Progress Review 1: Improved Child Functioning

IMPROVED CHILD FUNCTIONING: To what extent is this child showing functional improvements in areas of developmental delay and developmentally appropriate gains in other functional areas over the past six months or since admission to early intervention services, if less than six months?

A child receiving early intervention services should be demonstrating positive developmental gains and improved performance in key functional areas. Such life function areas, broadly defined, include:

- Physical (movement/mobility)
- Vision
- Hearing
- Communication
- Social/emotional (socialization)
- Adaptive (self-help, self-regulation)
- Cognitive (learning/pre-literacy skills)
- Health

As a result of therapeutic intervention and support, targeted developmental delays are expected to be minimized as functioning in key life areas is developed. Effective treatment response is accompanied by skill and performance gains in major life functions, hopefully advancing the child to normal functioning ranges or to reasonable functional ranges due to effects of condition or diagnosis. Children receiving appropriate early intervention are expected to show progress in functional development over the course of treatment. The purpose of this review is to determine the child's level of recent progress. Progress should be assessed by comparing the child's performance today to the child's level of performance six months ago or upon admission if less that six months have passed. The reviewer should use the scale provided below to report the degree of progress reported by informants and records in this case.

Description and Rating of the Child's Progress

Description of the Progress Observed for the Child	Rating Level
◆ **Optimal Progress and Improvement.** The child is making excellent developmental progress in areas of delay at a level well above expectation. Development in other non-delayed life areas may be at or above normal ranges. The child is able to maintain an excellent level of functioning.	**6** ☐
◆ **Good Progress and Improvement.** The child is making good developmental progress in areas of delay at expectation. Continuing delays may pose no more than minor functional impairments in daily life activities. Development in other non-delayed life areas may be within normal limits. The child is able to maintain a good level of functioning.	**5** ☐
◆ **Fair Progress and Improvement.** The child is making fair developmental progress in areas of delay at a level somewhat near expectation. Continuing delays may pose some minor functional impairments in daily life activities. Development in other non-delayed life areas is within normal limits.	**4** ☐
◆ **Marginal Progress and Improvement.** The child is making limited or inconsistent developmental progress in areas of delay that remain at a level somewhat below expectation. Continuing delays may pose some minor to moderate functional impairments in daily life activities. Development in other non-delayed life areas may be somewhat less than age appropriate at this time.	**3** ☐
◆ **No Progress or Improvement.** The child is making little or no consistent progress in areas of delay that remain at a level substantially below expectation. Continuing delays may pose some moderate to major functional impairments in daily life activities. Development in other non-delayed life areas may be substantially less than age appropriate at this time.	**2** ☐
◆ **Decline or Regression.** The child is showing further decline in development in previously assessed areas of delay or may be showing regression in some specific skill areas. Increasing delays and falling further behind the child's age peers may signal an emerging pattern of developmental disability that will require ongoing developmental and special educational services.	**1** ☐

Progress Review 2: Enhanced Caregiver Capacity

ENHANCED CAREGIVER CAPACITY: • To what extent have this child's caregivers enhanced their ability to meet the basic and special needs of this child over the past six months or since the child's admission to early intervention services, if less than six months?

Scoring Rule: This indicator may be rated for a foster, kinship, or adoptive home where the child may live and/or for a birth home where the child may live or have unsupervised visits. Thus, this indicator may be applied to either or both birth parent and substitute caregiver.

The IFSP for a child and caregiver is designed to provide parent training and supports, both formal and informal, to enhance and increase the capacity of caregivers to recognize, understand, and meet the particular needs of a young child presenting developmental delays or disabling conditions. Caregivers are provided opportunities to acquire new skills and knowledge required to meet the special needs of the child within home, child care, and community settings. As a result of training, support, and assistance, the child's caregivers should demonstrate the acquisition and use of new skills and knowledge and, with these gains, demonstrate an increased ability to meet the child's basic and special needs. As these new skills and knowledge are incorporated into daily child care and parenting activities, some formal services and supports may be decreased and eventually withdrawn as the caregivers, relying on acquired skills and informal support, continue to parent the child successfully. Progress should be assessed by comparing the caregiver's performance today to the caregiver's level of performance six months ago or upon admission if less that six months have passed. The reviewer should use the scale provided below to report the degree of progress in improving caregiver functioning reported by informants and records in this case.

Description and Rating of the Caregiver's Progress

Description of the Progress Observed for the Caregiver — Rating Level

- **Optimal Progress and Improvement.** The caregiver is demonstrating levels of caregiver functioning that show an **excellent level of progress and improvement** over the past six months or since beginning services. Caregiver skills and capacities may show vast improvement. Capacities gained may be fully consistent with current caregiving needs for this child. Training may be completed and formal supports may no longer be necessary at the high level provided upon beginning IFSP or other family support services. The caregiver is able to maintain an excellent level of functioning.

  6 ☐ Birth parent ☐ Sub. c'giver

- **Good Progress and Improvement.** The caregiver is demonstrating levels of caregiver functioning that show a **good level of progress and improvement** over the past six months or since beginning services. Caregiver skills and capacities may show substantial improvement. Capacities gained may be largely consistent with current caregiving needs for this child. Training may be near completion and formal supports may no longer be necessary at the higher level provided upon beginning IFSP or other family support services. The caregiver is able to maintain a good level of functioning.

  5 ☐ Birth parent ☐ Sub. c'giver

- **Fair Progress and Improvement.** The caregiver is demonstrating levels of caregiver functioning that show a **minimally adequate to fair level of progress and improvement** over the past six months or since beginning services. Caregiver skills and capacities may show some improvement. Capacities gained may be somewhat consistent with current caregiving needs for this child. Training may be in progress and formal supports may be continuing at or near the level provided upon beginning IFSP or other family support services.

  4 ☐ Birth parent ☐ Sub. c'giver

- **Borderline Progress and Improvement.** The caregiver is demonstrating levels of caregiver functioning that show a **limited or inconsistent level of progress and improvement** over the past six months or since beginning services. Caregiver skills and capacities may show little improvement. Capacities gained may be somewhat less than the current caregiving needs for this child. Training may be inconsistently attended and formal supports may be continuing at or near the level provided upon beginning IFSP or other family support services.

  3 ☐ Birth parent ☐ Sub. c'giver

- **Poor Progress.** The caregiver is demonstrating levels of caregiver functioning that show a **poor level of progress with little to no improvement in caregiving** capacities over the past six months or since beginning services. Caregiver skills and capacities may show no functional change. Capacities gained may be substantially less than the current caregiving needs for this child. Training may not be attended and formal supports may be continuing at or above the level provided upon beginning IFSP or other family support services.

  2 ☐ Birth parent ☐ Sub. c'giver

- **No Progress or Caregiver Change. EITHER** the child's caregiver six months ago or upon program entry if less than six months ago has declined to participate in services aimed at improving caregiver functioning. **- OR -** The child's caregiver has recently changed, putting a new caregiver into the child's life who is just beginning to learn about the child and who may just be beginning to receive parent training and other formal supports.

  1 ☐ Birth parent ☐ Sub. c'giver

- **Not Applicable** for birth parent if the child is not living in the birth home and will not be returning to the birth home within 30 days, or does not have unsupervised visit. Substitute caregiver is rated NA if child is living in the birth home.

  NA ☐ Birth parent ☐ Sub. c'giver

Progress Review 3: Improved Family Participation in Community

IMPROVED FAMILY PARTICIPATION IN COMMUNITY: To what extent has this family demonstrated increased participation in activities of community life over the past six months or since admission to services, if less than six months?

Scoring Rule: This indicator may be rated for a foster, kinship, or adoptive home where the child may live and/or for a birth home where the child may live or have unsupervised visits. Thus, this indicator may be applied to either or both birth parent and substitute caregiver.

Young children and their families deserve to lead fulfilling lives that include opportunities to participate in activities and roles valued by the community. Parents prefer early intervention services that are easy to do, fit into their daily lives, and emphasize children doing and learning things that help them become part of family and community life. Activities in the community for a family may include: family outings, attending church functions, using playgrounds and parks, community rituals surrounding holidays and special events, attending sporting activities and events, family errands such as grocery shopping, and spending time with friends and extended family. Community settings are the natural learning environments that enable children to acquire and use important life skills. Community activities may be with adults, other children, and objects or materials. The IFSP should provide outcomes and supports that help the family attain a desired level of community participation and involvement. Early intervention program staff should offer inclusive services and provide accommodations for activities to meet the needs of the child and family for participation in community activities. Integrating an infant or toddler with special needs into community settings and activities may require special training and support for family members and other community caregivers as well as special accommodations in activities. Progress should be assessed by comparing the family's community participation today to the level of participation six months ago or upon admission if less that six months have passed. The reviewer should use the scale provided below to report the degree of progress in improving family participation in the community reported by informants and records in this case.

Description and Rating of the Family's Progress

Description of the Progress Observed for the Family	Rating Level
◆ **Optimal Progress.** The family has demonstrated an excellent level of progress and improvement in their participation in community life activities in relation to outcomes and activities in their IFSP or through their own initiative. The family may have more than doubled the number or frequency of monthly community activities over the past six months or the family is able to maintain an excellent level of community participation.	**6** ☐ Birth parent ☐ Sub. c'giver
◆ **Good Progress.** The family has demonstrated a good and substantial level of progress and improvement in their participation in community life activities in relation to outcomes and activities in their IFSP or through their own initiative. The family may have nearly doubled the number or frequency of monthly community activities over the past six months or the family is able to maintain a good level of community participation.	**5** ☐ Birth parent ☐ Sub. c'giver
◆ **Fair Progress.** The family has demonstrated a minimal to fair level of progress and improvement in their participation in community life activities in relation to outcomes and activities in their IFSP or through their own initiative. The family may have increased by half the number or frequency of monthly community activities over the past six months.	**4** ☐ Birth parent ☐ Sub. c'giver
◆ **Borderline Progress.** The family has demonstrated a limited or inconsistent level of progress and improvement in their participation in community life activities in relation to outcomes and activities in their IFSP, if any, or through their own initiative. The family may have increased by a quarter the number or frequency of monthly community activities over the past six months.	**3** ☐ Birth parent ☐ Sub. c'giver
◆ **No Progress.** The family has demonstrated very little or no progress and improvement in their participation in community life activities in relation to outcomes and activities in their IFSP, if any, or through their own initiative. The family may not have increased the number or frequency of monthly community activities over the past six months.	**2** ☐ Birth parent ☐ Sub. c'giver
◆ **Decline/Regression.** The family has demonstrated a decline or regression in their participation in community life activities in relation to outcomes and activities in their IFSP, if any, or through their own initiative or the family may reduced the number or frequency of monthly community activities over the past six months.	**1** ☐ Birth parent ☐ Sub. c'giver
◆ **Not Applicable.** The family (birth and/or substitute) was already well integrated into the community and improvement in this area was not necessary.	**NA** ☐ Birth parent ☐ Sub. c'giver

Progress Review 4: Progress toward IFSP Outcomes

PROGRESS TOWARD IFSP OUTCOMES: To what extent has the child and family made progress toward attainment of outcomes set in their IFSP over the past six months or since admission, if less than six months?

Each child and family provided early intervention services should have an IFSP that directs those services toward the attainment of specific outcomes designed for the child, caregiver, or family unit. Intervention strategies, services, and supports are provided to achieve the IFSP outcomes. This review focuses on the attainment of IFSP outcomes and progress made toward the attainment of other IFSP outcomes over the past six months or since admission, if less than six months have passed. In making this review, each outcome set in the family's IFSP should be identified and probed to determine which outcomes, if any, have been attained over the past six months and which outcomes have evidence of progress made from baseline starting points. Abandoned outcomes should be set aside after determining the reasons for abandonment. Outcomes attained should be noted and counted as progress is made, taking into account the scope, pace, and difficulty of accomplishment. Progress made on outcomes yet to be attained should be evaluated based on the nature, scope, pace, and difficulty of the changes being made. Progress should be assessed by comparing the child or caregiver's status today to the level of performance six months ago or upon admission if less that six months have passed. The reviewer should use the scale provided below to report the degree of progress in attainment of IFSP outcomes reported by informants and records in this case.

Description and Rating of the Child and Family's Recent Progress

Description of the Progress Observed for this Child and Family	Rating Level
◆ **Optimal Progress.** Based on a review of IFSP outcomes attained and progress achieved, as determined from case records, progress notes, and informant interviews, progress toward outcome attainment is judged to be optimal. As appropriate to schedule, all IFSP outcomes have been attained or are showing progress toward attainment at a rate exceeding reasonable service team expectations.	**6** ☐
◆ **Good Progress.** Based on a review of IFSP outcomes attained and progress achieved, as determined from case records, progress notes, and informant interviews, progress toward outcome attainment is judged to be good. As appropriate to schedule, most IFSP outcomes have been or are being attained at a rate consistent with service team expectations.	**5** ☐
◆ **Fair Progress.** Based on a review of IFSP outcomes attained and progress achieved, as determined from case records, progress notes, and informant interviews, progress toward outcome attainment is judged to be minimally adequate to fair. As appropriate to schedule, some reasonable to challenging outcomes have been attained or are showing progress toward attainment at a rate somewhat lower than service team expectations.	**4** ☐
◆ **Marginal Progress.** Based on a review of IFSP outcomes attained and progress achieved, as determined from case records, progress notes, and informant interviews, progress toward outcome attainment is judged to be limited or inconsistent. As appropriate to schedule, few outcomes have yet to be attained or are showing progress toward attainment, falling far short of service team expectations.	**3** ☐
◆ **No Progress.** Based on a review of IFSP outcomes, as determined from case records, progress notes, and informant interviews, progress toward outcome attainment is judged not to be occurring. No outcomes have been attained or are not showing recent progress toward attainment. Some appropriate outcomes may have been abandoned or are being disregarded in the service process.	**2** ☐
◆ **Decline/Regression.** Based on a review of IFSP outcomes and evidence of change, as determined from case records, progress notes, and informant interviews, the child or family may be showing decline or regression from baseline measures used for setting IFSP outcomes or may have regressed after making some early progress toward some outcomes.	**1** ☐

Note on Assessing Performance Indicators

Performance, as measured in these indicators, focuses on the practice situation observed for the child over the past 90 days (three months). The focus is placed on the dominant pattern observed over this time period. In the unlikely event that the pattern has made a significant change within the 90-day period, the most recent performance situation should be reflected in the rating. The 90-day rule-of-thumb should be applied except when the wording within an indicator rating instructs the review to consider a different time period or when the child has received services for less than 90 days.

SECTION 3

PRACTICE PERFORMANCE

Indicators of Practice Performance **Page**

Indicators of Practice Attributes & Assets

Service Review 1: Family Engagement

FAMILY ENGAGEMENT: **• Are the service coordinator and service providers developing and maintaining a mutually beneficial partnership with the family that will sustain engagement and commitment to change? • Are family members or substitute caregivers active participants in the process by which service decisions are made? • Are parents/caregivers partners in planning, providing, and monitoring supports and services for the child? • If family members are reluctant to participate, are reasonable efforts being made to engage them and to support their participation?**

Scoring Rule: *This indicator may be rated for a foster, kinship, or adoptive home where the child may live and/or for a parent home where the child may live or have unsupervised visits. Thus, this indicator may be applied to either or both birth parent and substitute caregiver.*

Whose service plan and process is it—the service consumer's, the funders', or the providers' plan? It's important for the **child's family to have a sense of personal ownership** in the IFSP and decision process. If not, the likelihood of its success is small. Service plans are made to benefit the child and family by helping to create conditions under which the child can be successful in school and life. Services need to build on the strengths of the child and family and should reflect their strengths, views, and preferences. If arrangements are not seen as helpful and dependable by the family, services offered are not likely to be beneficial. The **central focus** of this review is that the child's family members (caregivers) be **active participants in shaping and directing services** that impact their lives. Emphasis is placed on direct and ongoing involvement in all phases of service: assessment, planning, provider selection, monitoring, modifications, and evaluation. Allowances needs to be made when services are imposed by court order for the child or family rather than being voluntary. Child and family satisfaction may be a useful indicator of participation and ownership.

Determine from Informants, Plans, and Records

1. Has the service coordinator invited family members who needs to be involved?
2. Does the family say they were listened to during IFSP decision making?
3. What service options were presented and discussed with parents?
4. Do family members routinely participate in:
   - ☐ Evaluation and assessment?
   - ☐ Planning services?
   - ☐ Monitoring and modifications?
   - ☐ Evaluation of results?
   - ☐ IFSP service team meetings?
5. If the child and family do not participate, what are the reasons/barriers? How is the service coordinator attempting to involve the family members in the service process?
6. Are other people involved in the service process? If so, who and to what extent—extended family, neighbors, friends, community members?
7. How are child and family strengths and priorities reflected in assessments, plans, and services?
8. Are the family and service coordinator kept fully informed about the current status of service plan implementation, barriers, and emerging issues? If not, why not?
   - ☐ The parents know the outcomes of their service plan.
   - ☐ The child and family know their service providers by name and personal experience. [Except when explicitly forbidden by court order]
   - ☐ Service providers respond to requests for assistance in a timely manner.
9. Does the family feel that their cultural values were respected throughout the service process? If not, what are the reasons?
10. Does the family show enthusiasm about their interactions with service providers?
11. Are service providers comfortable working with family members as partners?
12. Are families comfortable working with service providers as their partners?

Facts Used in Rating Performance

Service Review 1: Family Engagement

Description and Rating of Service System Performance

Description of the System Performance Situation Observed for the Family and Service Coordinator | Rating Level*

- **Optimal Family Engagement**. Key family members and/or the child's substitute caregiver(s) are full, effective, and ongoing participants in major aspects of assessment, planning services, making service arrangements, selecting providers, monitoring, and evaluating services and results. Special accommodations or supports are offered as needed to assist participation. Caregivers participate in planning outcomes, deciding on services, and shaping the service process to support and achieve life ambitions. **- OR -** Excellent service coordinator efforts (i.e., early, continued, varied, and appropriate actions) have been made and are continuing to be made to engage reluctant or difficult-to-reach/engage family members and promote their participation. [High quality sustained pattern for at least six months, or as long as the family has received services, if less than six months.]

  6
  ☐ Birth family
  ☐ Sub. c'giver
  ☐ Serv. coord.

- **Good Family Engagement**. Key family members and/or the child's substitute caregiver(s) are regular participants in most aspects of assessment, planning services, making service arrangements, selecting providers, monitoring, and evaluating services and results. Meetings are scheduled at times convenient for the family and caregiver, when needed. Caregivers participate in planning outcomes, major activities, and service arrangements. **- OR -** Good, substantial service coordinator efforts are being made to engage with reluctant family members and to promote participation. Supports to facilitate participation are repeatedly being offered. [Good quality sustained pattern for at least three months, or for as long as the family has received services, if less than three months.]

  5
  ☐ Birth family
  ☐ Sub. c'giver
  ☐ Serv. coord.

- **Fair Family Engagement**. Key family members and/or the child's substitute caregiver(s) selectively participate in offering assessment information, planning services, and providing feedback about service satisfaction. Caregivers somewhat participate in planning service objectives and deciding between attractive and appropriate service options offered. **- OR -** Fair, minimal service coordinator efforts are being made to engage with reluctant family members and to promote participation. Special accommodations to facilitate participation may be offered or made on some occasions to encourage participation. [Minimally adequate pattern, past 30 days.]

  4
  ☐ Birth family
  ☐ Sub. c'giver
  ☐ Serv. coord.

- **Marginal Family Engagement**. Key family members and/or the child's substitute caregiver(s) are notified of family service team meetings. Caregivers are allowed to attend service planning meetings and offer comments. Meetings are held at the convenience of provider staff. Participation is limited to planning activities and annual evaluation activities. **- OR -** Inconsistent service coordinator efforts are being made to engage with reluctant family members and to promote participation. Some accommodations to facilitate participation would be made, but only if requested by the family or caregiver. [Somewhat inadequate pattern, past 30 days]

  3
  ☐ Birth family
  ☐ Sub. c'giver
  ☐ Serv. coord.

- **Poor Family Engagement**. Key family members and/or the child's substitute caregiver(s) are notified late about the family service team meetings (age ten or older and capable). Caregivers are occasionally allowed to attend service planning meetings. Meetings are held at the convenience of provider staff. Plans are made before the meetings and parents are expected to accept what is offered. **- OR -** Occasional-to-rare service coordinator efforts have been made to engage with reluctant members, but with little effect. [Inadequate, dynamic pattern of concern, past 30 days.]

  2
  ☐ Birth family
  ☐ Sub. c'giver
  ☐ Serv. coord.

- **No Family Engagement**. Service planning and decision-making activities are conducted at times and places or in ways that prevent effective family participation. Decisions are made without the knowledge or consent of caregivers and other family members. Services are denied because of failure to show or comply. Appropriate and attractive alternative strategies, supports, and services are not offered. Important information is withheld from parents or caregivers. Procedural safeguards may be violated. **- OR -** After initial and possibly unsuccessful efforts by the service coordinator to engage the family, further efforts to engage reluctant family members were either not attempted or soon abandoned. [Adverse, dynamic pattern of major concern, past 30 days.]

  1
  ☐ Birth family
  ☐ Sub. c'giver
  ☐ Serv. coord.

- **Not Applicable** for birth family if the child is not living in the birth home and will not be returning to the birth home within 30 days, or does not have unsupervised visit. Substitute caregiver is rated NA if child is living in the birth home.

  NA
  ☐ Birth family
  ☐ Sub. c'giver

Service Review 2: Service Team Formation

SERVICE TEAM FORMATION: • Do the persons who compose the service team of the child and family collectively possess the technical skills, knowledge of the family, authority, and access to the resources necessary to organize effective services for a child and family of this complexity and cultural background?

Parents, professionals, paid service providers, and other friends and supporters from the family, daily settings, or neighborhood may comprise a service/support team for the child and family. Such team representation may be required to assure that a **necessary combination** of technical skills, cultural knowledge, and personal interests and contributions are formed and maintained for the child and family. Collectively, the team needs to have the technical and cultural competence, family knowledge, authority to act in behalf of funders and to commit resources, and ability to flexibly assemble supports and resources in response to specific needs. It is important for members of the team to have the time available to fulfill commitments made to the child/family. **Team competence, authority, relationships with the family, and opportunities of members to perform as a team are essential**. The focus of this review is placed upon the formation and composition of the service team. In reviewing the formation of the service team, the reviewer should remember that there is **no fixed formula** for team composition. Rather, consideration is based on what persons are necessary to provide effective intervention, treatment, and support for this child and family. The performance and effectiveness of the service team is addressed in Service Review 3: Service Team Functioning, not in this review item.

Determine from Informants, Plans, and Records

1. Who are the members of the service team for this child and family? Are all service agencies (e.g., child welfare, health care) involved with the child and family represented on the service team? (Refer to page 3, Professionals Supporting the Child and Family)

2. How and by whom were team members selected?

3. Has the service coordinator taken the responsibility for convening the team and facilitating the development and implementation of the IFSP?

4. Is there a person on the service team who shares the same language and culture as the child and family (other than the child and parent)?

5. Which service team members did the family invite to participate? Does the family believe that these are the "right people" for them?

6. Do team members have the authority to commit resources for the child and family? Did these members help to develop the current IFSP for this child and family?

7. Is the composition and membership of this team likely to remain stable over the next six months? If not, what impact are the expected changes likely to have?

8. Does the composition of the team change as needed to respond to new needs?

Facts Used in Rating Performance

NOTE:

The service coordinator is a member of the service team who is responsible for convening the team, facilitating planning and monitoring activities, keeping the team up to date on service implementation and results, and maintaining the IFSP and case record for the family and provider. To fulfill this central role, the service coordinator needs to have the necessary technical skills and knowledge to carrry out assigned duties.

Service/IFSP Team Members

281—120.35 Participants at initial IFSP meeting.
The initial IFSP meeting must include:

1. *A parent of the child;*
2. *Other family members as requested by a parent , if feasible;*
3. *An advocate or person outside the family, if a parent request that the person participate;*
4. *The service coordinator who has been working with the family since the initial referral of the child for evaluation, or who has been designated by Early ACCESS to be responsible for implementation of the IFSP;*
5. *A person or persons directly involved in conducting the evaluations and assessment;*
6. *Persons who may be providing services to the child and family as appropriate; and*
7. *A primary health care provider or designee, if feasible.*

—Iowa Administration Rules

Service Review 2: Service Team Formation

Description and Rating of Service System Performance

Description of the System Performance Situation Observed for the Child and Family — Rating Level

- **Optimal Service Team Formation.** Members of the child's service team collectively possess the technical skills, family knowledge, and authority necessary to effectively serve a child and family of this complexity and culture. The service team demonstrates the willingness to supply necessary resources as well as a commitment of the time and effort required to produce effective services and positive results for this child and family. The family feels the "right people" are on the current team and participate in decision making at key planning meetings. **6** ☐

- **Good Service Team Formation.** Members of the child's service team generally have the technical skills, family knowledge, authority and willingness to supply necessary resources, and adequate opportunity to produce effective services and positive results for this child and family. Most members of the team have been together since the creation of the current IFSP for this child and are expected to remain intact for at least another three months, if needed. The family feels most of the "right people" are on the team and are participating in the key decisions being made about needs and services. **5** ☐

- **Fair Service Team Formation.** Members of the child's service team minimally have the technical skills, family knowledge, authority and willingness to supply necessary resources, and time committed to produce adequate services with promising results for this child and family. Key team members have been together since the creation of the current IFSP and are expected to remain involved for at least another three months, if needed. The family feels some of the "right people" are on the team and generally participate in making key decisions. **4** ☐

- **Marginal Service Team Formation.** Some, but not all, members of the child's service team minimally have the technical skills, family knowledge, authority and willingness to supply necessary resources, and adequate time availability to meet the needs of a child and family of this complexity and culture. Some team members have been together since the creation of the current IFSP. Composition of the service team may be unstable or have incomplete membership at this time. Some of the "right people" are on the team but sometimes miss key decision-making meetings. **3** ☐

- **Poor Service Team Formation.** Collectively, members of the child's service team lack the technical skills, family knowledge, authority to supply necessary resources, and opportunity to meet the needs of a child and family of this complexity and culture. Few team members have been together since the creation of the current IFSP. Composition of the service team has been unstable or had incomplete membership for a substantial period of recent service planning and implementation activities. A few of the "right people" are on the team but may seldom show up for meetings. **2** ☐

- **Absent Service Team.** The individuals involved with the child and family do not constitute a complete team, nor have these persons formed or convened a working team for conducting service assessment, planning, or implementation activities. These may not be the "right people" for this child/family's service team. **1** ☐

Service Review 3: Service Team Functioning

SERVICE TEAM FUNCTIONING: • Do members of the service team for this child and family collectively function as a unified team in planning services and evaluating results? • Do the actions of the service team reflect a coherent pattern of effective teamwork and collaborative problem-solving actions that benefit the child and family in a manner consistent with the principles of family-centered practice?

This review focuses on the **functional performance** of the service team in collaborative problem solving, providing effective services, and achieving positive results with the child and family. Team functioning and decision-making processes needs to be consistent with the guiding principles of family-centered practice. Good communication is fundamental to effective team functioning and requires full disclosure, mutual respect, and regular interaction. The service coordinator plays a key role in communication and facilitation. **Evidence of effective team functioning lies in its performance over time and in the results it achieves for the child and family.** The focus and fit of services, authenticity of relationships and commitments, unity of effort, dependability of service system performance, and connectedness of the child and family to critical resources all derive from the functioning of the service team. Present child status, family participation and satisfaction, and achievement of effective results are important indicators about the functionality of the service team and need to be taken into account when making this review. Service team functioning is dependent, in part, on the composition and stability of the service team (see Service Review 2: Service Team Formation).

Determine from Informants, Plans, and Records

1 Are the parents an equal partner in planning and guiding services?

2. Is the family satisfied with the functioning of the team?

3. Are persons with similar backgrounds to the family members functioning as advisors in shaping service team decisions?

4. Do team members commit and ensure dependable delivery of services and resources for the child/family?

5. Are service team decisions consistent with efforts unified across all service agencies involved with the child and family?

6. Does the team demonstrate an effective ability to develop, implement, and monitor the child's IFSP?

7. Do members of the team demonstrate an understanding of family-centered principles in the design of the IFSP and use of formal and informal resources for this child and family?

8. Are all members of the team kept fully informed of the status of the child and the implementation of planned services?

9. Does the team use informal and formal resources/supports as appropriate to address IFSP outcomes, strategies, and activities?

10. Is the service coordinator providing leadership in convening and facilitating team meetings?

Facts Used in Rating Performance

Meetings

Is a family-centered approach used that ensures to the family's voice is central and heard in the planning of supports and services for the family?

Service Review 3: Service Team Functioning

Description and Rating of Service System Performance

Description of the System Performance Situation Observed for the Child and Family — Rating Level

- **Optimal Service Team Functioning.** Members of the service team demonstrate an excellent, well-established pattern of highly effective teamwork and collaborative problem solving that is benefiting the child and family in a manner fully consistent with the principles of family-centered practice. Family participation and satisfaction may be excellent. [High quality sustained pattern for at least six months, or as long as the family has received services, if less than six months.] **6** ☐

- **Good Service Team Functioning.** Members of the service team demonstrate a good and consistent pattern of effective teamwork and collaborative problem solving that is benefiting the child and family in a manner generally consistent with the principles of family-centered practice. Family participation and satisfaction may be good. [Good quality sustained pattern for at least three months, or for as long as the family has received services, if less than three months.] **5** ☐

- **Fair Service Team Functioning.** Members of the service team demonstrate a fairly adequate pattern of effective teamwork and collaborative problem solving that shows promise in benefiting the child and family. Actions are at least minimally consistent with the principles of family-centered practice. Family participation and satisfaction may be fair or better. [Minimally adequate pattern, past 30 days.] **4** ☐

- **Marginal Service Team Functioning.** Members of the service team demonstrate an inconsistent pattern of effective teamwork and collaborative problem solving that may create difficulty in getting positive results for the child and family. Actions are sometimes inconsistent with the principles of family-centered practice. Family participation and satisfaction may be marginal. [Somewhat inadequate pattern, past 30 days] **3** ☐

- **Poor Service Team Functioning.** Members of the service team demonstrate a pattern of ineffective teamwork and poor problem solving for the child and family. Actions are often inconsistent with the principles of family-centered practice. Family participation and satisfaction may be marginal to poor. [Inadequate, dynamic pattern of concern, past 30 days.] **2** ☐

- **Absent or Adverse Service Team Functioning. EITHER** there is no functional service team for this child and family. **- OR -** The actions and decisions made by the team are inappropriate, adverse, and/or contradictory to the principles of family-centered practice. [Adverse, dynamic pattern of major concern, past 30 days.] **1** ☐

Service Review 4: Evaluation, Assessment, Understanding

EVALUATION, ASSESSMENT, UNDERSTANDING: • Are the current, obvious, and substantial strengths, needs, and risks of the child and family identified through existing evaluations and assessments, both formal and informal, so that all providers collectively share a holistic understanding of the child and family and how to provide effective services for them? • Does the service team have a working understanding of family strengths and needs in order to assist the family in supporting their child at home and in typical daily settings?

The purpose of evaluation and assessment is to gather and analyze information that will lead to **sound decision making** about development and well-being of a child and support for the family. As appropriate to the case situation, a combination of clinical, functional, and informal assessment techniques need to be used to determine the strengths, capabilities, needs, risks, and lifestyle preferences of the child and family. Once gathered, the information should be analyzed and synthesized (along with monitoring results) to form a comprehensive or holistic understanding of the child and his/her social support networks at home, in daily settings, and in the community. Evaluation and assessment techniques, both formal and informal, need to be appropriate for the child's age, ability, culture, language or system of communication, and social support networks. **Assessment is an ongoing process.** It is important for new assessments to be performed promptly when IFSP outcomes are met, when emergent needs or problems arise, or when changes are necessary. New assessment findings need to be incorporated in strategies, services, and supports in the IFSP for the child and family. Recent monitoring findings and service results should be used to update the understanding of the child and family situation. Members of the service team, use their assessment knowledge to form a holistic picture that provides a **shared understanding of the child and family**. This provides a **common core of team intelligence** for unifying efforts, planning joint strategies, sharing resources, and achieving a good match of supports and services for the child and family.

Determine from Informants, Plans, and Records

1. Are indicated evaluations and assessments actually performed and used? If other assessments were needed, were they completed? If not, what are the reasons?

☐ Physical development	☐ Health status and service access
☐ Vision	☐ Family resources
☐ Hearing	☐ Family priorities
☐ Motor development	☐ Family concerns
☐ Communication dev.	☐ Safety, stability, permanency, if applicable
☐ Social/emotional dev.	☐ Information from medical home
☐ Adaptive development	☐ Other: _____
☐ Cognitive development	_____

2. Are evaluations conducted by two or more personnel trained to use appropriate methods and procedures?
3. Are evaluations and assessments appropriate for the child and family's culture and communication abilities?
4. Are evaluations/assessments conducted in natural settings and everyday activities, when applicable? If not, where are they conducted and why?
5. Do assessments identify the family's strengths, needs, capabilities, and wishes?
6. How often is evaluation and assessment information updated by the service team? Are changes in the child and family's situation and condition identified and assessed as needs arise? If not, why not?
7. How do members of the service team utilize evaluation and assessment information and experience to form a common understanding of the child and family? Does the team use health information from health providers (e.g, pediatrician/family practice physician, specialist, dentist) as appropriate?

Facts Used in Rating Performance

Note

Understandings gained via evaluation and assessment processes provide the basis for planning of the IFSP by the service team.

Service Review 4: Evaluation, Assessment, Understanding

Determine from Informants, Plans, and Records	Facts Used in Rating Performance
8. Are critical underlying issues and key stability and safety risks identified, analyzed, and understood by the members of the service team? Does the service team have sufficient knowledge and understanding to develop a responsive service plan, including safety plans where necessary?	

Description and Rating of Service System Performance

Description of the System Performance Situation Observed for the Child and Family — Rating Level

- **Optimal Assessment & Understanding**. All current, obvious, and important strengths and needs of the child and family have been identified through evaluations, assessments, monitoring results, and collected experiences of the service team. A complete, ongoing, and accurate view has been synthesized by the service team. Members of the service team share a rich, full understanding of the child and family necessary for unifying responsive efforts, sharing resources, and assembling a good mix and fit of supports and services in the IFSP. [High quality sustained pattern for at least six months, or as long as the family has received services, if less than six months.] — **6** ☐

- **Good Assessment & Understanding**. A comprehensive set of strengths and needs of the child and family have been identified through evaluations, assessments, monitoring results, and collected experiences of the service team. An ongoing and accurate holistic view has been synthesized by the team. Members of the service team share a substantial common understanding of the child and family necessary for unifying service efforts, sharing resources, and assembling supports and services in the IFSP. [Good quality sustained pattern for at least three months, or for as long as the family has received services, if less than three months.] — **5** ☐

- **Fair Assessment & Understanding**. Selected strengths and needs of the child and family have been identified through formal and informal assessments and from progress notes of the service team. A periodic holistic impression is compiled by the team for planning purposes. Most members of the service team have a common but loose understanding of the child and family necessary for collaborative service planning. [Minimally adequate pattern, past 30 days.] — **4** ☐

- **Marginal Assessment & Understanding**. Selected strengths and needs of the child and family have been identified through formal methods, but some obvious and important needs or preferences have been overlooked or excluded. A periodic "snapshot" is compiled by the service team but is limited in scope and detail. Some members of the service team share a rough understanding of the child and family necessary for collaborative service planning, others do not. This picture for planning may be somewhat misfocused or sketchy. [Inadequate, dynamic pattern of concern, past 30 days.] — **3** ☐

- **Poor Assessment & Understanding**. Few important strengths and needs of the child and family have been identified through evaluations or assessments. Obvious and important needs or preferences have been overlooked or excluded. The service team's understanding of the child and family is limited in scope, detail, and usefulness. Few, if any, members of the service team have an understanding of the child and family necessary for collaborative service planning. This picture for planning may be misfocused, incomplete, or obsolete. [Inadequate, dynamic pattern of concern, past 30 days.] — **2** ☐

- **Absent Assessment or Adverse Understanding**. Important strengths and needs of the child and family have not been identified.. Essential strengths, needs, risks, or preferences are unknown or misunderstood. Members of the service team lack an understanding or have a distorted or misleading view of the child and family that is used for decision making. No current, accurate picture of the child and family exists for meaningful use in planning. Misunderstandings are present and may cause confusion in service planning. [Adverse, dynamic pattern of major concern, past 30 days.] — **1** ☐

Service Review 5: IFSP Planning

IFSP: • Is the IFSP relevant to the child and family's needs and outcomes? • Does the IFSP address focal concerns, underlying causes, and known health risks and stress functional outcomes? • Is the IFSP coherent in the selection and integration of strategies, supports, services, and timelines offered? • Does the IFSP reflect the preferences and choices of the family? • Is the IFSP modified promptly as outcomes are met and circumstances change?

Does this child and family have multiple plans, each developed by a separate agency or service provider? Or, does the child/family have a single integrated service plan working as a comprehensive service organizer that is focused by clear goals and guiding strategies developed by the family? The IFSP specifies the outcomes, roles, strategies, resources, and timelines for coordinated provision of assistance, supports, and services for the child and family to be successful. To be acceptable, the IFSP needs to be based on the assessment and understanding of the child and family; reflect the views and preferences of the family; be directed toward the achievement of goals and success of the child and family; be implementable; include informal as well as formal resources; be culturally appropriate; and be modified frequently, based on changing circumstances, experience gained, and progress made. It is the vitality and intelligence of the planning process that is of essence here, not the elegance of a written document. The IFSP is the working document for the service team outlining the family's goals and the path and service processes to be followed in achieving those results.

Determine from Informants, Plans, and Records

1. Are the family-identified priorities addressed in the IFSP?

2. Are needs and outcomes expressed in the family's words?

3. Are the child and family's strengths reflected in the plan?

4. Does the IFSP:
   - ☐ Target needs that brought the child and family to the attention of Early ACCESS?
   - ☐ Address underlying priorities/concerns?
   - ☐ Provide emergency procedures and trained supports for health or safety risks of an urgent nature for the child or caregiver?
   - ☐ Address particular needs of the child at home, child care, and in the community?
   - ☐ Address any particular needs of the caregiver/family?
   - ☐ Provide assignment of responsibilities and timelines?
   - ☐ Reflect and support preferences of the child and family?
   - ☐ Unify the efforts and integrate services of all service providers?

5. Are all required and other early intervention services received by the child and caregiver addressed in the IFSP?

6. Are planned services appropriate for the family's composition and culture?

7. Are informal supports provided in the IFSP?

8. Is the strategic path and service process realistic? Does the plan make sense? Is it likely to achieve the desired results for this child and family?

9. Will providers be capable of implementing the IFSP as written? If implemented as written, will the planned services likely achieve the stated goals?

Facts Used in Rating Performance

From Iowa Administrative rules 281-120.14, required early intervention services include:

- *Assistive technology device*
- *Assistive technology service*
- *Audiology services*
- *Family training, counseling and home visits*
- *Health services*
- *Medical services only for diagnostic or evaluation purposes*
- *Nursing services*
- *Nutrition services*
- *Occupational therapy*
- *Physical therapy*
- *Psychological services*
- *Socialwork services*
- *Special instruction*
- *Speech-language pathology services*
- *Transportation and other related costs*
- *Vision services*

Note: Required and Other early intervention services. Required early intervention services are those services that are defined in the Administrative Rules for Early ACCESS and are required to be provided to eligible children, based on needs identified during evaluations/assessment and agreed-upon by the IFSP team. Other early intervention services are additional services that are not defined in the rules, but are those that the child/family need/use. The IFSP documents both required and other services that are needed to achieve IFSP outcomes. Examples of other services include respite care; physician/clinic medical services not included in the rule definition; well baby check ups, and music therapy (not an inclusive list).

Service Review 5: IFSP Planning

Determine from Informants, Plans, and Records	Facts Used in Rating Performance
10. Did the team agree on the priority of the child and family needs 11. Are the outcomes reflective of the family's desires and are they realistic? 12. Will the IFSP lead to increased caregiver capacities, a decrease of the child's delays, successful transitions, and successful child development?	

Description and Rating of Support Network Performance

Description of the System Performance Situation Observed for the Child and Family — Rating Level

- **Optimal IFSP and Process.** There is an excellent IFSP process and plan for this child/family that is approved and fully supported by the family, all agencies, and providers involved. The IFSP builds upon the assessment and understanding of the child and family situation. It adapts quickly to changes in life circumstances and local services. The IFSP is sensible in its strategy, sequence, assembly, and use of formal and informal resources. Primary caregivers are fully supported as necessary to meet the needs of the child. The IFSP is fully consistent with principles of family-centered practice and may be producing excellent results at this time. [High quality sustained pattern for at least six months, or as long as the family has received services, if less than six months.] **6** ☐

- **Good IFSP and Process.** There is a good IFSP process and plan for this child/family that is approved and supported by the family, most agencies, and providers involved. The IFSP builds upon the assessment and understanding of the child and family situation. It adapts to changes in life circumstances and local services. The IFSP is generally sensible in its strategy, sequence, assembly, and use of formal and informal resources. Primary caregivers are usually supported as necessary to meet the needs of the child. The IFSP is substantially consistent with principles of family-centered practice and may be producing good results at this time. [Good quality sustained pattern for at least three months, or for as long as the family has received services, if less than three months.] **5** ☐

- **Fair IFSP and Process.** There is a minimally adequate to fair IFSP process and plan for this child/family that is supported by the family, some agencies, and providers involved. The IFSP somewhat reflects the assessment and understanding of the child and family situation. It is periodically adjusted to reflect changes in life circumstances and local services. The IFSP is somewhat sensible in its strategy, sequence, assembly, and use of formal and informal resources. Primary caregivers are minimally supported as necessary to meet the needs of the child. The IFSP is minimally consistent with principles of family-centered practice and may be producing fair results at this time. [Minimally adequate pattern, past 30 days.] **4** ☐

- **Marginal IFSP and Process.** There is a limited or inconsistent IFSP process and plan for this child/family that may be supported by few agencies and providers involved. Plans may not reflect the assessment or may work toward divergent or conflicting goals. The service process may not respond on a timely basis to changes in life circumstances and local services. Plans may create gaps in services or duplication of resources. Caregivers may not receive adequate supports. The IFSP is somewhat inconsistent with principles of family-centered practice and may be producing marginal results at this time. [Somewhat inadequate pattern, past 30 days] **3** ☐

- **Poor IFSP and Process.** There is a limited or inconsistent IFSP process and plan for this child/family that may not be supported by some agencies and providers involved. Plans may not reflect an adequate assessment or may work toward divergent or conflicting goals. The service process may respond poorly, if at all, to changes in life circumstances and local services. Plans may create gaps in services or duplication of resources. Caregivers may lack adequate supports. The IFSP is largely inconsistent with principles of family-centered practice and may be producing poor results at this time. [Inadequate, dynamic pattern of concern, past 30 days.] **2** ☐

- **Absent or Misdirected IFSP and Process.** No effective collaboration exists among persons serving the family. Providers may lack common or accurate assessment knowledge and may have divergent or conflicting goals. Either no IFSP or a misdirected or incomplete IFSP exists at this time. Numerous breakdowns in oversight and substantial gaps in services and duplication of efforts may be evident. Caregivers may lack essential supports (e.g., housing, health care) leading to increasing family dysfunction. The current IFSP cannot drive or support good practice. [Adverse, dynamic pattern of major concern, past 30 days.] **1** ☐

Service Review 6: IFSP Implementation

IFSP IMPLEMENTATION: • Are the services and activities specified in the IFSP for the child and family being: (1) implemented as planned, (2) delivered in a timely and competent manner, and (3) delivered at an appropriate level of intensity? • Are the necessary supports, services, and resources available to the child and family to meet the needs identified in the IFSP?

To fulfill the purpose of early intervention for the child and family, the provisions of the IFSP have to be implemented via timely delivery of adequate services. Implementation involves the arrangement of supports and delivery of services according to the IFSP. Acceptable provision of services means that the agreed-upon strategies, supports, services, and other intervention activities are being delivered in a timely and competent manner, consistent with family identified needs and preferences. Timeliness of service delivery, appropriate to the urgency of need, is an important criterion of acceptability. **Delivery of services by persons having the necessary skills, resources, time, and opportunity to provide supports and services commensurate with the urgency and complexity of the child's needs and family's situation** is essential for producing desired results. To be adequate, the intensity and consistency of service delivery need to be commensurate with that required to produce desired results for the child and family. **Timeliness, competence, intensity, and consistency lead to dependability**, **family satisfaction, and positive results.** An appropriate implementation process needs to be dynamic and interactive, offering ongoing adaptation of service arrangements in response to frequent feedback received about changing situations, emerging needs, and results being achieved.

Determine from Informants, Plans, and Records	Facts Used in Rating Performance
1. Are the needed services and supports currently being delivered/implemented as described in the IFSP? Is each service and support readily accessible when needed? Are services provided consistently and on a timely basis?	
2. Are supports and services provided in natural settings (home, child care setting, and community)? If not, why not? Where are they provided?	
3. Are informal supports developed and used at home, at child care setting, and in the community as a part of the service process?	
4. Is each support and service described in the IFSP readily accessible when needed with sufficient intensity and consistency to achieve expected results?	
5. Collectively, are the supports and services offered in the IFSP being delivered with sufficient intensity and consistency to achieve IFSP outcomes and expected results?	
6. Are the supports and services offered in the IFSP being delivered by appropriately licensed, credentialed, or trained staff?	
7. Are service providers receiving the direction, support, and supervision necessary for adequate and effective service delivery and achievement of positive results for the child and family?	
8. Are problems occurring in implementation promptly detected and solved by the service coordinator or other appropriate person?	
9. Are the supports and services imbedded in naturally occurring learning opportunities?	

Service Review 6: IFSP Implementation

Determine from Informants, Plans, and Records	Facts Used in Rating Performance
10. Is the IFSP updated as outcomes are met, transitions are crossed, and life circumstances change at home?	

Description and Rating of Service System Performance

Description of the System Performance Situation Observed for the Child and Family — Rating Level

- **Optimal IFSP Implementation.** The strategies, supports, and services in the IFSP are being **fully implemented in a timely and competent manner**, consistent with the principles of family-centered practice. The quality, quantity, consistency, and intensity of services are fully sufficient to produce desired results for the child and family. To keep services responsive and dependable, ongoing adaptations are made quickly as situations change, needs emerge, and results are known. Demonstration of "reasonable efforts" in service implementation is excellent in this case. [High quality sustained pattern for at least six months, or as long as the family has received services, if less than six months.] — **6** ☐

- **Dependable, Effective IFSP Implementation.** Essential strategies, supports, and services in the IFSP are being **substantially implemented in a timely and competent manner**, consistent with the principles of family-centered practice. The quality, quantity, and intensity of services are generally sufficient to produce desired results. To keep services responsive and dependable, adaptations are made periodically as situations change, needs emerge, and results are known. Demonstration of "reasonable efforts" in service implementation is good, substantial, and continuous in this case. [Good quality sustained pattern for at least three months, or for as long as the family has received services, if less than three months.] — **5** ☐

- **Minimally Responsive IFSP Implementation.** Essential strategies, supports, and services in the IFSP are being **minimally implemented in a timely and competent manner**, consistent with the principles of family-centered practice. The quality and intensity of services minimally lead to desired results. To keep services responsive, adjustments are made periodically, based on monitoring results or a request made by the child, parent, or teacher. Demonstration of "reasonable efforts" in service implementation is minimally adequate to fair in this case. [Minimally adequate pattern, past 30 days.] — **4** ☐

- **Minor Problems with IFSP Implementation.** Essential strategies, supports, and services in the IFSP are being **inconsistently implemented**. Timeliness, competence, or consistency with the principles of family-centered practice may be minor problems. The intensity of services may be weak in yielding desired results. Adjustments may be made occasionally, based on monitoring results or a request made by the child, parent, or teacher. Demonstration of "reasonable efforts" in service implementation is limited or inconsistent in this case. [Somewhat inadequate pattern, past 30 days] — **3** ☐

- **Fragmented or Inconsistent IFSP Implementation.** Essential strategies, supports, and services in the IFSP are being **poorly or inconsistently implemented**. Timeliness, competency, or consistency with the principles of family-centered practice may have substantial problems. The intensity of services may be poor in yielding desired results. Adjustments may be inadequate in keeping services responsive, dependable, or effective. Demonstration of "reasonable efforts" in service implementation is poor (not timely, not effective, not consistently attended to) in this case. [Inadequate, dynamic pattern of concern, past 30 days.] — **2** ☐

- **Absent or Misdirected IFSP Implementation. Few**, if any, essential strategies, supports, and services in the IFSP **are being implemented**. Timeliness, competency, and consistency with the principles of family-centered practice are major problems. The intensity and dependability of services may be inadequate to yield desired results. Adjustments in services are not occurring on a adequate basis, resulting in poor responsiveness to needs and unacceptable results. Demonstration of "reasonable efforts" in service implementation is missing or performed in an inappropriate way in this case. [Adverse, dynamic pattern of major concern, past 30 days.] — **1** ☐

Service Review 7: Service Coordination

SERVICE COORDINATION: • Is there effective coordination and continuity in the organization and provision of services? • Is there a single point of coordination and accountability for assuring that the IFSP is implemented, monitoring activities are conducted, and information is shared with the service team so that appropriate and timely changes are made in strategies, supports, and services across settings and providers?

The service coordinator is the assigned person responsible for facilitating and coordinating the service process for the child and family. The person filling this role needs to have the **competence** necessary to perform essential functions for the family and meet the needs of the child being served. It is important for this person to have the **authority to convene** parents, providers, and all funding agency representatives for purposes of planning, assembly of supports and services, monitoring implementation and results, and modifying supports and services. This person needs to be able to **advocate** on behalf of the family without conflicts of interest that may be associated with a particular agency or provider. The person's caseload size or work schedule needs to afford the **opportunity** to adequately coordinate services for every person on the caseload. In a case where several agencies and providers are involved, collaboration is necessary to achieve and sustain a coordinated and effective service process. The central concern of this evaluation is whether all necessary functions performed by service planners, providers, and the child and caregiver are organized and integrated to achieve the strategic goals of intervention and benefits for the child and family. Effective service coordination requires the integration of simultaneous interventions into a unified process involving a team approach to implementation. Effective service coordination requires competence in family engagement, assessment, IFSP planning, implementation, monitoring, problem solving, evaluation, and IFSP modification.

Determine from Informants, Plans, and Records

1. Is there a service coordinator for the child and family who is responsible for planning and implementing the IFSP and for linking service providers involved in its implementation? Is the service coordinator from the profession most immediately relevant to meet the needs of the child and family?

2. Do all service team members, including family members, have a common understanding of the IFSP and related IDEA requirements for early intervention and transition, where indicated, to 3-5 year old special education services?

3. Where indicated, are supports and services being integrated and coordinated across all intervening agencies and service providers involved with this child and family?

4. Are services being arranged, implemented, monitored, evaluated, and modified as necessary to keep the IFSP relevant, appropriate, and effective?

5. Is there a mechanism for identifying emerging problems and developing appropriate responses and adjustments in the plan and service process?

6. Is there adequate communication so that the service team and any other key parties know the current status of the child and family?

7. Does the service coordinator have sufficient knowledge and training to meet the child'sand family's presenting needs?

8. Does the service coordinator have sufficient authority to require interveners and providers to implement services as written on the IFSP?

Facts Used in Rating Performance

Service Coordination includes:

- *Following family-centered practice principles.*
- *Engaging the family as partners in practice.*
- *Assessing and understanding the family situation.*
- *Convening the service team, as necessary.*
- *Planning team meeting activities.*
- *Facilitating the service team process.*
- *Helping the service team to reach consensus on decisions and courses of action.*
- *Developing the IFSP with the family and team.*
- *Securing and assembling resources, supports, and services for IFSP implementation.*
- *Making timely and appropriate referrals for service/resources.*
- *Coordinating services across providers, funding sources, and other intervening agencies.*
- *Monitoring service implementation and IDEA timelines.*
- *Ensuring child and family safety and well-being.*
- *Identifying and reporting implementation problems to service team members.*
- *Keeping team members informed and involved in problem-solving efforts.*
- *Driving implementation of the IFSP forward to goal attainment and transition on a timely basis.*
- *Preparing for and achieving case closure following transition to 3-5 year old services.*
- *Maintaining adequate documentation.*
- *Demonstrating "reasonable efforts" in practice.*

Service Review 7: Service Coordination

Determine from Informants, Plans, and Records	Facts Used in Rating Performance
9. Does the service coordinator and service team collectively share a sense of accountability for achieving desired results of this child/family's IFSP? 10. Is the service coordinator knowledgeable about resources and funding available in the community? Does the service coordinator have a support system with access to current and accurate information? 11. Is there a process for the service coordinator to seek necessary support if the IFSP is not being implemented as written?	

Description and Rating of Service System Performance

Description of the System Performance Situation Observed for the Child and Family — Rating Level

- **Optimal Service Coordination.** There is highly effective coordination of and accountability for the child/family's supports, services, and results. The service coordinator (working in collaboration with the family and service team) fully demonstrates the competence, responsibility, and opportunity necessary to plan, secure, assemble, schedule, coordinate, monitor, and adapt supports and services by achieving desired results for this child/family. Supports and services are fully integrated across settings and providers and are consistently timely, appropriate, effective, and satisfying to the child/family. Service coordinator has sufficient authority to coordinate across agency lines and to serve as the family's single point of coordination. [High quality sustained pattern for at least six months, or as long as the family has received services, if less than six months.] — **6** ☐

- **Dependable, Effective Service Coordination.** There is generally effective coordination of and accountability for the child/family's services and results. The service coordinator (working in collaboration with the child, family, and service team) usually demonstrates the competence, responsibility, and opportunity necessary to plan, secure, assemble, schedule, coordinate, monitor, and adapt supports and services by achieving desired results for this child/family. Services are generally integrated across settings and providers and are usually timely, appropriate, effective, and satisfying to the child/family. [Good quality sustained pattern for at least three months, or for as long as the family has received services, if less than three months.] — **5** ☐

- **Fair Service Coordination.** There is minimally adequate coordination of and accountability for the child/family's services and results. The service coordinator (working in collaboration with the child, family, and service team) minimally demonstrates the competence and opportunity necessary to plan, secure, assemble, schedule, coordinate, monitor, and adapt supports and services. Services are minimally integrated across settings and providers and are usually timely, appropriate, and satisfying to the child/family. [Minimally adequate pattern, past 30 days.] — **4** ☐

- **Marginal Service Coordination.** There is limited coordination of services with little accountability for service delivery and results. The service coordinator (possibly working independently of the child/family or in the absence of a service team) may lack the ability and opportunity necessary to plan, secure, assemble, schedule, coordinate, monitor, and adapt supports and services. Services are somewhat fragmented across settings and providers. Breakdowns in services may occur occasionally. [Somewhat inadequate pattern, past 30 days] — **3** ☐

- **Fragmented or Inconsistent Service Coordination.** There is substantially inadequate coordination of services for this child/family. The service coordinator (working independently of the child/family or in the absence of a service team) may lack the competence, responsibility, or opportunity to plan, secure, assemble, schedule, coordinate, monitor, and adapt supports and services. Services are substantially fragmented across settings. Breakdowns may be frequent and risks may not be adequately managed for the child/family. [Inadequate, dynamic pattern of concern, past 30 days.] — **2** ☐

- **Absent or Misdirected Service Coordination.** There is no coordination of or accountability for the child/family's services and results. Needed services may be absent or fragmented. The child/family may "get lost in the system" for periods of time, leaving them at elevated risk of harm or poor future outcomes. Efforts made are inappropriate or adverse in effect. [Adverse, dynamic pattern of major concern, past 30 days.] — **1** ☐

Service Review 8: Monitoring, Evaluation, Modification

MONITORING, EVALUATION, MODIFICATION: • Are the child and family's status, service process, and results routinely monitored to ensure that the IFSP maintains relevance, integrity, and appropriateness? • Are service strategies and results evaluated to understand achievement of results, what strategies are working for the child and family, and which strategies and services require modification? • Are timely modifications made to keep the planning and service provision processes effective and self-correcting?

What's working now for this child and family? Are desired results being produced? What things need changing? An ongoing examination process needs to be used to monitor service implementation, check progress, identify emergent needs and problems, and modify services in a timely manner. Tracking and adaptation provide the "learning" and "change" processes that make the service process appropriate and, ultimately, effective for the child and caregiver.

The IFSP needs to be modified when objectives are met, strategies are determined to be ineffective, new preferences or dissatisfactions with existing strategies or services are expressed, and/or new needs or circumstances arise. The service coordinator for the child and family needs to play a central role in monitoring and modifying planned strategies, services, supports, and results. Members of the service team (including the child and caregiver) need to apply the knowledge gained through ongoing assessments, monitoring, and periodic evaluations to adapt strategies, supports, and services. This learning and change process is necessary to find what works for the child and caregiver. Learning what works is a continuing process. **Getting successful results depends on appropriate service control processes.**

Determine from Informants, Plans, and Records

1. How often is the status of the child and family monitored/reviewed? Note how service implementation and results are monitored by the service coordinator (e.g., face-to-face contacts, telephone contact, and meetings with family, child, service providers, reviewing reports from providers).

2. Is the implementation of the service delivery process being tracked? Is progress or lack of progress being identified, noted, and acted upon?

3. Are detected problems being reported and addressed promptly?

4. Are identified needs and problems being acted on?

5. Is there a clear and consistent pattern of successful adaptive service changes that have been made in response to use of short-term results?

6. Is the service process modified as outcomes are met? Is the service process modified if no progress is observed? If not, why not?

7. Is the IFSP updated as outcomes are met or dropped because they are no longer a need or a priority?

   ☐ Is the IFSP updated if no progress is observed? If not, why not?
   ☐ How does the service coordinator update and modify the IFSP?

8. Does the family use both their own perceptions and provider information to evaluate progress of outcomes?

Facts Used in Rating Performance

Note on Service Control Processes:

The child and family tracking, service monitoring, problem solving, results evaluation, strategy adaption, and IFSP modification processes form a self-correcting service control process. The central principle in the service control process is to find what works and change what does not work for the child and family. Use of a self-correcting service control process keeps the IFSP relevant, on track, and effective in meeting needs.

Service Review 8: Monitoring, Evaluation, Modification

Description and Rating of Service System Performance

Description of the System Performance Situation Observed for the Child and Family — Rating Level

- **Optimal Service Control Processes.** The strategies, supports, and services being provided to the child and family are highly responsive and appropriate to changing conditions. Continuous monitoring, tracking, and communication of child status and service results to the service team are occurring. Timely and smart adaptations are being made. Highly successful modifications are based on a rich knowledge of what things are working and not working for the child and family. [High quality sustained pattern for at least six months, or as long as the family has received services, if less than six months.] **6** ☐

- **Good Service Control Processes.** The strategies, supports, and services being provided to the child and family are generally responsive to changing conditions. Frequent monitoring, tracking, and communication of child status and service results are occurring. Generally successful adaptations are based on a basic knowledge of what things are working and not working for the child and family. [Good quality sustained pattern for at least three months, or for as long as the family has received services, if less than three months.] **5** ☐

- **Fair Service Control Processes.** The strategies, supports, and services being provided to the child and family are minimally responsive to changing conditions. Periodic monitoring, tracking, and communication of child status and service results is occurring. Usually successful adaptations to supports and services are being made. [Minimally adequate pattern, past 30 days.] **4** ☐

- **Marginal Service Control Processes.** The strategies, supports, and services being provided to the child and family are partially responsive to changing conditions. Occasional monitoring and communication of child status and service results is occurring. Partially successful adaptations are based on isolated facts of what is happening to the child and family. Their status may be adequate in some areas but unacceptable in others. The child or family could be at low risk of harm or poor outcomes. [Somewhat inadequate pattern, past 30 days] **3** ☐

- **Poor Service Control Processes.** Poor strategies, supports, and services may be provided to the child and family and may not be responsive to changing conditions. Rare monitoring, poor communications, and/or an inadequate service team may be unable to function effectively in planning, providing, monitoring, or adapting services. Few sensible modifications may be planned or implemented. Child and family status may be poor in several areas. The child or family could be at moderate-to-high risk of harm or poor outcomes. [Inadequate, dynamic pattern of concern, past 30 days.] **2** ☐

- **Absent or Adverse Service Control Processes.** Strategies, supports, and services may be limited, undependable, or conflicting for child and family. No monitoring or communications may occur and/or an inadequate service team may be unable to function effectively in planning, providing, monitoring, or adapting services. Current supports and services may have become non-responsive to the current needs of the child and family. The service process appears to be "out of control." Child and family status may be generally poor. The child or family could be at high risk of harm or poor outcomes. [Adverse, dynamic pattern of major concern, past 30 days.] **1** ☐

Service Review 9: Family-Centered Practice

FAMILY-CENTERED PRACTICE: • Is the family unit a central focus of attention in the IFSP? • Is emphasis placed on assessing and building on family strengths and on the capacity the family to meet the needs of the child? • Is the family engaged in all aspects of the service process? • Is the family being linked with a more comprehensive, need-specific, and community-based network of supports and services?

Family-centered practice (FCP) makes the family an equal partner in the service planning process with professionals and service providers. The central goal of FCP is helping the family adequately nurture a child with a developmental delay or condition, manage the tasks of daily living attendant to the child's development and care, and remedy problem situations that arise. FCP works with the family to ensure the development, safety, and well-being of the child. The primary purpose of FCP is to strengthen the family's capacities for carrying out their responsibilities. FCP practitioners partner with the family to use their expert knowledge throughout the decision-making and goal-setting processes and to provide individualized, culturally-competent [see Service Review 10], and relevant services for the child and family. Family-centered interventions assist in mobilizing resources to maximize communication, shared planning, and collaboration among neighborhood and community systems that are directly involved with the family. In FCP, the family is engaged in ways relevant to the situation and sensitive to values of their culture. Assessment of strengths supports the development of IFSP strategies built on family competencies, assets, and resources including the parents' preferred learning style(s). Awareness of strengths supports the development of IFSP strategies built on family competencies, assets, and resources. The service team and coordinator ensures that the family has reasonable access to a flexible, affordable, individualized array of services so that the family can meet the needs of the child while preserving the functioning of the family. Especially for a family under stress, a respectful, non-judgmental, and non-blaming approach is used. The focus of this review is placed on evidence of the use of FCP in the provision of services to the focus child and family.

Determine from Informants, Plans, and Records	Facts Used in Rating Performance
1. Are the parents and other caregiving members of the child's family working as equal partners with professionals and providers in meeting the needs of the child? What do the parents say?	
2. To what degree is the family unit a focus of assessment and the provision of supports and services in this case?	
3. What are the strengths, capabilities, assets, and resources of this family? How are family strengths, capacities, and resources being assessed in this case?	
4. How has the family been prepared to participate in service processes? To what degree have/are parents and other caregivers involved in assessment, planning, implementation, monitoring, and evaluation processes?	
5. How are the child and family strengths and preferences reflected in assessments, plans, and services provided?	
6. How is the family's informal support system incorporated into plans? If the family lacks an informal support system, is the family being supported in developing one?	
7. Is the family the ultimate decision maker in choosing appropriate service modes and levels?	
8. Does the family feel respected and valued throughout the service process?	
9. Are services flexible enough to allow for the individual needs of the family to be met without causing hardship or undue stress in receiving the services?	

Service Review 9: Family-Centered Practice

Description and Rating of Service System Performance

Description of the System Performance Situation Observed for the Child and Family — Rating Level

- **Optimal Family-Centered Practice.** Record review and informant interviews reveal that the service team has placed the family unit as a central focus of attention in the IFSP to a high degree. Excellent emphasis is placed on assessing and building on family strengths and on the capacity of the family to meet the needs of the child. The family's informal support system is fully incorporated into plans. If the family lacks an informal support system, the family may be provided excellent supports in developing one. The family is fully engaged in all aspects of the service process. The service team and coordinator are doing an excellent job in linking the family with a more comprehensive, need-specific, and community-based network of supports and services. The family feels deeply respected and truly valued throughout the service process. **6** ☐

- **Good Family-Centered Practice.** Record review and informant interviews reveal that the service team has placed the family unit as a central focus of attention in the IFSP to a substantial degree. Strong emphasis is placed on assessing and building on family strengths and on the capacity of the family to meet the needs of the child. The family's informal support system is well incorporated into plans. If the family lacks an informal support system, the family may be provided good and substantial supports in developing one. The family is generally engaged in all aspects of the service process. The service team and coordinator are doing a good job in linking the family with a more comprehensive, need-specific, and community-based network of supports and services. The family feels generally respected and usually valued throughout the service process. **5** ☐

- **Fair Family-Centered Practice.** Record review and informant interviews reveal that the service team has placed the family unit as a central focus of attention in the IFSP to a minimally adequate to fair degree. Some emphasis is placed on assessing and building on family strengths and on the capacity of the family to meet the needs of the child. The family's informal support system is somewhat incorporated into plans. If the family lacks an informal support system, the family may be provided minimal to fair supports in developing one. The family is somewhat engaged in most aspects of the service process. The service team and coordinator are doing a fair job in linking the family with a more comprehensive, need-specific, and community-based network of supports and services. The family feels somewhat respected and valued throughout the service process. **4** ☐

- **Marginal Family-Centered Practice.** Record review and informant interviews reveal that the service team has placed the family unit as a central focus of attention in the IFSP to a limited or inconsistent degree. Little emphasis is placed on assessing and building on family strengths and on the capacity of the family to meet the needs of the child. The family's informal support system is marginally incorporated into plans. If the family lacks an informal support system, the family may be provided few supports in developing one. The family may be marginally engaged in the service process. The service team and coordinator are doing a limited or inconsistent job in linking the family with a more comprehensive, need-specific, and community-based network of supports and services. The family does not feel very respected and valued throughout the service process. **3** ☐

- **Poor Family-Centered Practice.** Record review and informant interviews reveal that the service team has not placing much attention on the family unit as a central focus in the IFSP. Little, if any, emphasis is placed on assessing and building on family strengths and on the capacity of the family to meet the needs of the child. The family's informal support system is poorly incorporated into plans. If the family lacks an informal support system, the family may be provided inadequate supports in developing one. The family may be poorly engaged in the service process. The service team and coordinator are doing a poor job in linking the family with a more comprehensive, need-specific, and community-based network of supports and services. The family does not feel respected and valued throughout the service process. **2** ☐

- **Absent Family-Centered Practice.** There is little or no evidence of family-centered practice in this case. The family may feel left out or lost in the service process. Decisions may be made by professionals or providers without input from the family or without the family present during the decision-making process. Services operate at the convenience of providers, possibly causing hardships for the family. The family may feel ignored or disrespected. **1** ☐

Service Review 10: Cultural Accommodations

CULTURAL ACCOMMODATIONS: • Are any significant cultural issues of the child and family being identified and addressed in practice? • Are strategies, services, and supports provided made culturally appropriate via special accommodations for the family in the engagement, assessment, planning, and service delivery processes used by the practitioners involved?

Child and family service systems serve an increasing proportion of children and families from underserved minority populations. If such systems are to effectively serve these children and their families, the impact of culture and cultural difference must be recognized and accommodated. Cultural accommodations enable practitioners to serve individuals of diverse cultural backgrounds effectively. Such accommodations include valuing cultural diversity, understanding how it impacts on normal functioning and problems during the course of intervention, and adapting service processes to meet the needs of culturally diverse children and their families. Properly applied in practice, cultural accommodations reduce the likelihood that matters of language, culture, custom, or belief will prevent or reduce the effectiveness of intervention efforts. The focus of this examination is placed on the child and family in which significant cultural issues are present in the case that must be understood and accommodated in order for desired results and outcomes to be achieved. This examination does not apply in a case in which matters of family language, culture, custom, or belief are not potential barriers or present impediments in the attainment of desired treatment results.

Determine from Informants, Plans, and Records

1. Are child and family cultural identities and related needs identified?

2. Specific cultural issues identified and addressed in this case are:
   - ☐ None
   - ☐ Racial:_____
   - ☐ Ethnic:_____
   - ☐ Religious:_____
   - ☐ Other:_____

3. If the child is Native American and placed outside the home, is the child placed in a Native American substitute care setting? If not, why not? What efforts were made to place the child in a Native American setting?

4. If the child is Native American, does the service plan include strategies and activities to maintain the child's natural cultural connections and affiliations?

5. Are assessments performed appropriate for the child's background?

6. Is the service provider of the same cultural background as this family or does the service provider have adequate knowledge of cultural issues relevant to service delivery for this child and family? Do the service providers respect family beliefs and customs?

7. If the child or caregiver has a primary language that is other than English, are translator and interpreter services provided? For the family? For the service team?

8. Are written materials provided in the family's primary language?

9. Has the service team explored natural, cultural, or community supports appropriate for this child and family? Where necessary, are family connections being maintained using culturally appropriate strategies and supports?

10. Are cultural differences impeding working relationships or service results with this child and family? What does the family say?

Facts Used in Rating Performance

Domains of Cultural Competence are:

- *Values and attitudes that promote mutual respect.*
- *Communication styles that show sensitivity.*
- *Community/consumer participation in developing policies, practices, and interventions that build on cultural understandings.*
- *Physical environment including settings, materials, and resources that are culturally and linguistically responsive.*
- *Policies and procedures that incorporate cultural/linguistic principles and multicultural practices.*
- *Population-based clinical practice that avoids misapplication of scientific knowledge and stereotyping groups.*
- *Training and professional development in culturally competent practice.*

Service Review 10: Cultural Accommodations

Description and Rating of Service System Performance

Description of the System Performance Situation Observed for the Child and Family — Rating Level

- **Optimal Cultural Understandings and Accommodations.** The child and family's cultural identity is recognized, is well understood, and services are tailored to meet related needs. Family cultural beliefs and customs are fully respected and well accommodated in service processes. All assessments are culturally appropriate and limitations or potential cultural biases are recognized. Service providers are fully knowledgeable about issues related to the child's identified culture and shape treatment planning and delivery appropriately. Other natural community helpers important to the child's culture are included in service planning and delivery. If needed, translation and interpreter services are provided in a culturally appropriate manner. Written materials are available in the family's primary language. [High quality sustained pattern for at least six months, or as long as the family has received services, if less than six months.] — **6** ☐

- **Good Cultural Understandings and Accommodations.** The child and family's cultural identity is recognized and services generally address related needs. Family cultural beliefs and customs are generally respected and taken into consideration for planning services. Most assessments are culturally appropriate and limitations or potential cultural bias is recognized. Service providers attempt to gain knowledge about issues related to the child's identified culture and arrange for knowledgeable supervision for treatment planning and service delivery. Other natural community helpers important to the child's culture are acknowledged and information is obtained from them. If needed, translation and interpreter services are available. Written materials are available in the family's primary language. [Good quality sustained pattern for at least three months, or for as long as the family has received services, if less than three months.] — **5** ☐

- **Fair Cultural Understandings and Accommodations.** The child's cultural identity is recognized and the provider acknowledges this in the assessment, treatment planning, and service delivery process. Family cultural beliefs and customs are usually acknowledged and services are planned in an effort to avoid violations. For example, the provider might acknowledge other natural community helpers important to the child's culture and works with the child and family to integrate those supports. If needed, translation and interpreter services are available most of the time. [Minimally adequate pattern, past 30 days.] — **4** ☐

- **Marginal Cultural Understandings and Accommodations.** The child's cultural identity is recognized and the provider acknowledges that assessment, treatment planning, or services are <u>not</u> a good fit but is seeking to improve these processes for this child and family. There may be evidence of cultural accommodations by this health provider/agency in some cases, although it is limited or inconsistent for this child. Family cultural beliefs and customs are not viewed as relevant to the assessment, treatment planning, or service delivery process. If needed, translation and interpreter services are only sporadically available. [Somewhat inadequate pattern, past 30 days] — **3** ☐

- **Poor Cultural Understandings and Accommodations.** The child's cultural identity is not recognized in the service process. Inappropriate assessment, treatment planning, or service delivery processes ignore child or family cultural beliefs and customs. If needed, translation and interpreter services may be limited or difficult to secure. Few, if any, provisions are made for cultural accommodations. [Inadequate, dynamic pattern of concern, past 30 days.] — **2** ☐

- **Adverse Cultural Understandings and Accommodations.** There is no evidence of cultural recognition or accommodation by behavioral health service providers in this case. The child and family's cultural identity may be treated with disrespect and their customs and beliefs may be ignored or treated as irrelevant. Inappropriate assessment, treatment planning, or service delivery processes ignore or violate child or family cultural beliefs and customs. If needed, translation and interpreter services are not provided. [Adverse, dynamic pattern of major concern, past 30 days.] — **1** ☐

- **Not Applicable.** The child is not of minority racial or ethnic background. **- OR -** The child/family does not identify any cultural issues or needs relevant for service system performance. — **NA** ☐

Service Review 11: Resource Availability

RESOURCE AVAILABILITY: • Are the supports, services, and resources (both informal and formal) necessary to meet the identified needs in the IFSP available for use by the child and family? • Are the flexible supports and unique service arrangements (both informal and formal) necessary to meet individual needs in the child's plans available for use by the child and family on a timely, adequate, and convenient local basis? • Are any unavailable but necessary resources identified?

An array of informal and formal supports and services is necessary to fulfill requirements of the IFSP. To respond to unique needs, supports may have to be created or assembled in special arrangements. Such unique and flexible support arrangements wrap services* around a child in his/her home or other daily setting so as to avoid placement in more restrictive settings away from home and child care. Some services may be unit-based (e.g., therapy) while others may be placement-based (e.g., therapeutic home). Supports can range from volunteer baby sitters to specialized respite care. Supports may be voluntarily provided by friends, neighbors, and churches or secured from provider agencies. Professional treatment services may be donated, offered through health care plans, or funded by government agencies. A combination of supports and services may be necessary to support and assist the child and family. For interveners to **exercise professional judgment** and for the family to **exercise choice** in the selection of treatment services and supports, an array of appropriate alternatives should be locally available. Such alternatives should present a variety of socially or therapeutically appropriate options that are readily accessible, have power to produce desired results, be available for use as needed, and be culturally compatible with the needs and values of the family. An adequate array may span supports and services from all sources that may be needed by the family. Selection of basic supports should begin with informal family network supports and generic community resources available to all citizens. Specialized and tailor-made supports and services should be developed or purchased only when necessary to supplement rather than supplant readily available supports and services of a satisfactory nature. Unavailable resources should be systematically identified to enable the network to meet the need.

Determine from Informants, Plans, and Records

1. Are all obvious and substantial needs matched with appropriate supports and services for this family? Will supports shift from formal to informal over time?
2. Have informal supports been developed or uncovered and used at home and in the community as a part of the service process?
3. Are resources matched to needs addressed in the IFSP?
4. Are resources provided within the family's home and neighborhood?
5. To what extent are informal resources of the family, extended family, neighborhood, civic clubs, churches, charitable organizations, local businesses, and general public services (e.g., recreation, public library, or transportation) used in providing supports for this family?
6. Is each support provided socially and culturally appropriate for the family?
7. Is the service team taking steps to locate or develop or advocate for previously unknown or undeveloped resources?
8. Did members of the family's service team have two or more appropriate service options from which to choose when recommending professional services?
9. Did the family have two or more appropriate options from which to choose when selecting supports and services?
10. Is each treatment service therapeutically appropriate for the child and family?
11. Is each service and support readily accessible when needed? If not, what is missing?
12. Were any of the supports and services tailor-made or assembled uniquely for this child or family? Are they sustainable as needed over time?
13. Is the combination of informal and formal supports and services used for this family sufficient for the child and family members to do well?
14. Is the combination of supports and services used for/by this family dependable and satisfactory from their point of view?
15. Has the service team taken the steps to identify resource gaps and notify the community?

Facts Used in Rating Performance

NOTE:

Use of unique, flexible, multiple service arrangements may be necessary to prevent placement by increasing the range and intensity of services in a child's home or daycare setting - OR - to return a child from a specialized treatment setting to his/her home and daycare settings successfully. Such use may require blending of funding across sources and bending of agency traditions that would limit or prevent success in individual child and family situations.

Service Review 11: Resource Availability

Description and Rating of Service System Performance

Description of the System Performance Situation Observed for the Child and Family — Rating Level

- **Optimal Resource Availability.** The array of supports and services is helping the child and family reach optimal levels of functioning necessary for them to make progress and live together successfully. A highly dependable combination of informal and, where necessary, formal supports and services is available, appropriate, used, and seen as very satisfactory by the family. The array provides a wide range of options that permits use of professional judgment about appropriate treatment interventions and family choice of providers. [High quality sustained pattern for at least six months, or as long as the family has received services, if less than six months.] **6** ☐

- **Good Resource Availability.** The array of supports and services is helping the child and family reach favorable levels of functioning necessary for them to make progress and live successfully together. A usually dependable combination of informal and formal supports and services is available, appropriate, used, and seen as generally satisfactory by the family. The array provides a narrow range of options that permits use of professional judgment and family choice of providers. The service team is taking steps to mobilize additional resources to give the family greater choice and/or provide resources to meet particular family needs. [Good quality sustained pattern for at least three months, or for as long as the family has received services, if less than three months.] **5** ☐

- **Fair Resource Availability.** The array of supports and services is available to the family to reach minimally acceptable levels of functioning necessary for them to make fair progress and live together successfully. A set of supports and services is usually available, somewhat appropriate, used, and seen as minimally satisfactory by the family. The array provides few options, limiting professional judgment and family choice in the selection of providers. The service team is considering taking steps to mobilize additional resources to give the family greater choice and/or provide resources to meet particular family needs but has not yet taken any steps. [Minimally adequate pattern, past 30 days.] **4** ☐

- **Marginal Resource Availability.** A somewhat limited array of supports and services may not be readily accessible or available to the family. A limited set of supports and services may be inconsistently available and used but may be seen as partially unsatisfactory by the family. The array provides few options, substantially limiting use of professional judgment and family choice in the selection of providers. The service team has not yet considered taking steps to mobilize additional resources to give the family greater choice and/or provide resources to meet particular family needs. [Somewhat inadequate pattern, past 30 days] **3** ☐

- **Poor Resource Availability.** A very limited array of supports and services may be inaccessible or inconsistently available to the family. Few supports and services may be available and used. They may be seen as generally unsatisfactory by the family. The array provides very few options, preventing use of professional judgment and family choice in the selection of providers. The service team has not considered taking steps to mobilize additional resources or may not be functioning effectively. [Inadequate, dynamic pattern of concern, past 30 days.] **2** ☐

- **Absent or Adverse Resource Availability.** Few, if any, supports and services are provided at this time. They may not fit the actual needs of the child and/or family well and may not be dependable over time. Because informal supports may not be well developed and because local services or funding is limited, any services may be offered on a "take it or leave it" basis. The family may be dissatisfied with or refuse services, and results may present a potential safety risk to family members. The service team may be powerless to alter the service availability situation or the child and family may lack a functioning service team. [Adverse, dynamic pattern of major concern, past 30 days.] **1** ☐

Service Review 12: Urgent Response Capability

URGENT RESPONSE CAPABILITY: Is there timely access to and provision of effective services to stabilize or resolve emergent or episodic problems of an urgent nature?

NOTE: *This review applies only to a child or family that, by history, has a demonstrated need for this service.*

A child who presents acute episodes of chronic health problems (e.g., allergy-induced anaphylactic shock, seizures, hemophilia, asthma, SIDS) or self-injurious behaviors may require immediate, specific, and possibly intensive services to meet the child's emergent need and to prevent harm from occurring to the child or others in the child's daily settings. For such children, an urgent response capability is necessary. Providing this capacity requires a health emergency "crisis plan," designed specifically for the child, that can be activated and implemented immediately. An alert procedure and crisis response capability has to be prepared in advance, be made a part of the IFSP or other appropriate crisis response or safety plan, and have prepared persons in the child's daily settings ready to implement the crisis response plan and a follow-along mechanism that tracks the child through the crisis period. The urgency and significance of an emerging need or problem of the child or family should be met with a timely and commensurate service response. The primary concern here is whether the child, caregivers, and service workers have timely access to support services necessary to stabilize or resolve emerging problems of an urgent nature. A child living in a home under child protective supervision may require a safety plan to be followed in the event of domestic violence, abandonment by the caregiver, or some other safety problem that has occurred previously in the home. A crisis or safety plan should be evaluated following every use to ensure that its provisions are effective and that persons responsible for its use know and perform key tasks.

Determine from Informants, Plans, and Records

To determine if this review area should be rated, consider the following matters:

- ☐ **Does the child present severe levels of acute and life-threatening health symptoms or behaviors? If so, do these symptoms present cyclically? Can crisis episodes be anticipated?**
- ☐ **Does the child have a chronic health condition with frequent acute episodes that needs to be taken into account in planning behavioral health services?**
- ☐ **Is this child's home under protective supervision of the child welfare agency?**
- ☐ **Have special risks* and a pattern of urgent needs been identified for this child?**
- ☐ **Are safety plans indicated and provided to manage special situations?**
- ☐ **Have emergency procedures (including 911 services) recently been used for this child or family within the past six months?**

1. Does this child or family have a crisis alert and response/safety plan?
2. Are emergent or urgent response services available when and as needed? Have emergent or urgent response services ever been denied? If so, why?
3. Is there an alert procedure and crisis response plan for this child or family specified in the IFSP and/or other appropriate service plan documents?
4. Are the persons who would send the alert and implement the crisis response plan aware of and ready to fulfill their assigned responsibilities?
5. Have the alert and crisis response processes been used in the past six months for this child or caregiver? If Yes, did they work effectively? Were such services timely?

Facts Used in Rating Performance

** Special Risks to Consider:*

- *Recent abuse, trauma, victimization*
- *Recent self-mutiliation or self-injury*
- *Recent severe aggression toward others*
- *Conflict or instability in the home*
- *Under CFSA custody or supervision for abuse, neglect, dependency*
- *Recent runaway, school suspension, self-endangering impulsive behavior*
- *Significant external impact (e.g., loss of a loved one, parental divorce, homelessness)*

Service Review 12: Urgent Response Capability

Description and Rating of Service System Performance

Description of the System Performance Situation Observed for the Child and Family — Rating Level

- **Optimal Urgent Response Capability.** All appropriate persons in the child's daily living, learning, and therapeutic settings are fully prepared and ready to implement the team alert, crisis response, and follow-along provisions of a well-tested and effective urgent response capability for the child. Alert and crisis/safety response processes, if used in the past six months, were performed in an excellent, reliable, and effective manner. **6** ☐

- **Good Urgent Response Capability.** Key persons in the child's daily living, learning, and therapeutic settings are generally prepared and ready to implement the team alert, crisis/safety response, and follow-along provisions of the child's urgent response plan. Plan provisions have been successfully tested via simulation or, if used in the past six months, worked reliably and acceptably well. **5** ☐

- **Fair Urgent Response Capability.** Key persons in the child's daily living, learning, and therapeutic settings are minimally prepared to implement the team alert, crisis/safety response, and follow-along provisions of the child's urgent response plan. Plan provisions are periodically reviewed with persons responsible for implementation. If used recently, crisis response was at least minimally successful in managing risks and securing necessary services. **4** ☐

- **Marginal Urgent Response Capability.** Some, but not all, of the key persons in the child's daily living, learning, and therapeutic settings are minimally prepared to implement the team alert, crisis/safety response, and follow-along provisions of the child's urgent response plan. **- OR -** Plan provisions are not tested or periodically reviewed with persons responsible for implementation. **- OR -** If used recently, crisis response revealed some minor-to-moderate problems in managing risks at an acceptable level or in securing necessary crisis services in an acceptable manner. **3** ☐

- **Poor Urgent Response Capability.** Key persons in the child's daily living, learning, and therapeutic settings are not adequately prepared to implement a team alert, crisis/safety response, and follow-along plan necessary for the child. **- OR -** Crisis/safety plan provisions are unrealistic, incomplete, unrehearsed, or untested. **- OR -** If used recently, crisis response revealed substantial problems in managing risks at an acceptable level or in securing crisis services in an acceptable manner. **2** ☐

- **Absent or Adverse Urgent Response Capability.** Key persons in the child's daily living, learning, and therapeutic settings are unprepared or unwilling to implement a team alert, crisis/safety response, and follow-along plan necessary for the child. **- OR -** A crisis/safety plan and response is necessary for this child but currently does not exist (except to call 911). **- OR -** If used recently, the crisis/safety response plan failed to manage risks adequately or to provide crisis supports or services in an acceptable manner. **1** ☐

- **Not Applicable.** The child has no history of medical crises or other emergencies within the past year. **NA** ☐

Service Review 13: Family Support & Training

FAMILY SUPPORT & TRAINING: • Is the family being supported and trained as necessary to perform essential parenting functions reliably for the child? • Is the service system connecting family members to informal supports that will assist them in being safe and function independently of formal supervision? Are there appropriate family support and training that address the child's special needs/conditions and its effects on the child's development and family life?

Caregivers are persons who provide parenting, assistance, supervision, and physical care for children in the home. Children with challenging physical/emotional/behavioral needs place much greater demands on the skills of a caregiver and resources of the home than do other children. Caregivers with lower cognitive abilities or those reared in unhealthy families—ones with abusive situations, or a reliance on excessive physical discipline, or high criticism/low warmth interactions—require more support, training, and guidance than caregivers who had more positive childhood experiences.

Caregivers and families who are currently isolated from a social network of support or have a weak network (as a result of such things as excessive mobility, family disputes, caregiver anxieties, poor transportation, or substance addiction) require assistance in making the connections to people, places, and activities that can help them develop or strengthen a network of informal supports that will sustain their efforts to become independent of formal supervision. A caring adult who has a significant and enduring relationship with the children is necessary for the well-being of the children. Such an adult may reside in the home or live nearby but sees the children often.

Determine from Informants, Plans, and Records	Formal Supports	Informal Supports
1. Do caregiver supports appear to be needed for this family?		
2. Is there an unconditionally caring adult for the children? How was he/she identified and engaged in the process? What role does the adult play in the family?		
3. Have nearby extended family members been contacted and reconnected with the family?		
4. Have family members been introduced to neighbors?		
5. Have family members been introduced to appropriate mutual support groups in the community (e.g., parents of newborns, Parents Anonymous, Alcoholics Anonymous, disability specific support groups)?		
6. Are family members being actively engaged in neighborhood and community educational and recreational activities? How are they being engaged?		
7. Are families being assisted to participate, as families, in community activities? How are they being assisted?		
8. Given these connections and supports, is the family able to meet the needs of the children?		
9. Given these connections, has the family been able to expand/strengthen its support network?		
10. Will the expanded support network be able to help the family achieve/sustain the outcomes and results planned in the IFSP?		
11. Have the family caregivers received information and/or training in the Early ACCESS process? If not, what were the barriers?		
12. Is the family given appropriate links to information and peer support related to the child's condition?		
13. Have family hardships and disruptions been minimized?		

Service Review 13: Family Support & Training

Determine from Informants, Plans, and Records	Formal Supports	Informal Supports
14. Does the family report that current supports are adequate, dependable, and truly supportive of the caregiver in meeting the child(ren)'s needs?		
15. Is the caregiver pleased with the expanded support network and the connections being made with support groups, activities, etc.?		

Description and Rating of Family Support and Training Performance

Description of the System Performance Situation Observed for the Family — Rating Level

- **Optimal Family Support and Training.** The family is receiving an excellent level of assistance, support, and training necessary for the family to meet the needs of the child and maintain stability of the home. The family has been able to optimally expand its functional support network by being connected to informal supports that provide a broad and effective set of supports for the family. The family has a capable and reliable support network that includes extended family, neighbors, and available community resources. [High quality sustained pattern for at least six months, or as long as the family has received services, if less than six months.] — **6** ☐

- **Good Family Support and Training.** The family is receiving a good and substantial level of assistance, support, and training necessary for the family to meet the needs of the child and maintain stability of the home. The family has been able to substantially expand its functional support network by being connected to informal supports to provide a good set of supports for the family. The family is developing a capable and reliable support network that includes extended family, neighbors, and available community resources. [Good quality sustained pattern for at least three months, or for as long as the family has received services, if less than three months.] — **5** ☐

- **Fair Family Support and Training.** The family is receiving a minimally adequate level of assistance, support, and training necessary for the family to meet the needs of the child and maintain stability of the home. The family is being connected to informal network supports. The family is developing a support network that includes extended family and neighbors. [Minimally adequate pattern, past 30 days.] — **4** ☐

- **Marginal Family Support and Training.** The family is receiving a somewhat marginal or limited level of assistance, support, and training necessary for the family to meet the needs of the child and maintain stability of the home. The family has not been connected to informal network supports and the family is unable to expand the network alone. The family does not have an adequate support network beyond extended family. [Somewhat inadequate pattern, past 30 days] — **3** ☐

- **Poor Family Support and Training.** The family is receiving a poor, substantially unacceptable level of assistance, support, and training necessary for the family to meet the needs of the child and maintain stability of the home. The family has not been connected to informal network supports and the family is unable to expand the network. There is no extended family to provide support. [Inadequate, dynamic pattern of concern, past 30 days.] — **2** ☐

- **Absent Family Support and Training.** The family is receiving no assistance, support, and training necessary for the family to meet the needs of the child and maintain stability of the home. The family has not been connected to informal network supports and is unable to expand the network without such assistance. There is no extended family to provide support or the existing family has problems that isolate members from other sources of needed support. [Adverse, dynamic pattern of major concern, past 30 days.] — **1** ☐

Service Review 14: Transition Process

TRANSITION: • If age appropriate or situation, is a well-planned transition process being implemented for this child and family? • Is the transition process comprehensive in scope and inclusive all who should participate? • Is the process family-centered and focused on the best interests of the child? • Are the relevant state and federal rules for IFSPs and IDEA Part C being followed?

Transition is effective when families are aware of and prepared for changes at the point of transition. Quality transitions result when professionals, systems, and families lay the groundwork well in advance. The transition should not be viewed as a singular event of a child moving from Part C early intervention services into other services; but rather as a well-staged change process. Persons and agencies who may receive the child as the next service providers should be a part of the transition planning process. As a child and family prepare to leave Early ACCESS services, strategies should be discussed and documented in the IFSP to address identified needs regarding the transition. These strategies should address how the family will continue to be supported in their efforts to meet the needs of their child. The service coordinator should discuss with the family the vision and priorities they have for their child and family. Options for transition should also be discussed and should include ways the family can continue to participate within their community. If particular supports are needed to make community participation possible, transition planning should address how these supports will be provided. The transition process should address all aspects important to the success of that service. In addition, families have full knowledge and developed skills so that they will be able to assume a role similar to that of the service coordinator when their child exits Early ACCESS. Transition must be viewed as an ongoing process and may occur at anytime.

Determine from Informants, Plans, and Records	Facts Used in Rating Performance
1. If this child is 30 months of age or older, what transition plans are now under way to ensure a smooth and successful transition to services for the child after exiting the Early ACCESS system?	
2. If the child is older than 33 months, is the transition planning taking substantial shape? Is the plan being implemented? Is the receiving agency participating?	
3. Is the family actively involved in the planning?	
4. Does the family feel that their wishes and needs are understood and taken into consideration? By the receiving agency and new providers?	
5. Are various options and points of view taken into consideration?	
6. If special education was one of the options being considered, was the local school district and area education agency involved in the early stages of transition planning?	
7. Over time, did the family receive clear, anticipatory transition information (e.g. that service providers, plans, frequency, location, etc. might/would change when the child turned three; that service coordination through Early ACCESS would end, etc.)?	
8. Is the family concerned about the forthcoming transition?	
9. Is there a plan to support the child and family's involvement in the community?	
10. If the family is moving to another state, has the family been referred to appropriate resources and services there?	
11. If the family has already transitioned from Early ACCESS, how do they feel about the transition process and the services they now receive?	

Service Review 14: Transition Process

Description and Rating of Service System Performance

Description of the System Performance Situation Observed for the Child and Family — Rating Level

- **Optimal Transition Process.** The transition has been identified and planned consistent with the child and family's known near-term future situation and IFSP-related considerations. What the family should know, be able to do, and have as supports to be successful after the transition occurs is being developed now. If a transition is imminent, all necessary arrangements (for supports and services) are being made to assure that the child and family are functioning successfully during and after the transition. If the child is age 30 months or older, excellent arrangements for a smooth transition to pre-k and other needed services (following discharge from the Early ACCESS program) are being made on a timely basis and are being fully implemented with all parties so that no lapses in needed services will occur. — **6** ☐

- **Good Transition Process.** The transition has been identified and discussed. What the family should know, be able to do, and have as supports to be successful are planned and being addressed. If a transition is imminent, essential arrangements (for supports and services) are being made to assist the family during and after the transition. If the child is age 30 months or older, good and substantial arrangements for a smooth transition to pre-k and other needed services (following discharge from the Early ACCESS program) are being made on a timely basis and are being well implemented with all parties so that no lapses in needed services will occur. — **5** ☐

- **Fair Transition Process.** The transition has been identified. What the family should know, be able to do, and have as supports to be successful are known and being used for planning. If a transition is imminent, basic arrangements (for supports and services) are minimally in place to assist the family during and after the transition. If the child is age 30 months or older, minimally adequate to fair arrangements for a smooth transition to pre-k and other needed services (following discharge from the Early ACCESS program) are being made on a timely basis and are being minimally implemented with all parties so that the probability of lapses in needed services are minimized. — **4** ☐

- **Marginal Transition Process.** A need for transition may be becoming recognized. What the family should know, be able to do, and have as supports to be successful have not been assessed and no plans have been made. If a transition is imminent, few or partial arrangements (for supports and services) are not in place to assist the family during and after the transition. If the child is age 30 months or older, limited arrangements for a smooth transition to pre-k and other needed services (following discharge from the Early ACCESS program) are being made and somewhat implemented with some parties so that the probability of lapses in needed services are somewhat reduced. — **3** ☐

- **Poor Transition Process.** A need for transition has not been identified. If a transition is imminent, adequate arrangements (for supports and services) are not in place to assist the family during and after the transition. If the child is age 30 months or older, few, if any, arrangements for a smooth transition to pre-k and other needed services (following discharge from the Early ACCESS program) are being made and/or are being poorly implemented with some parties so that lapses in needed services are likely to occur. — **2** ☐

- **No Transition Process.** The need for transition has not been considered although it should have been. If a transition is imminent, no arrangements (for supports and services) are in place to assist the family during and after the transition. If the child is age 30 months or older, no arrangements for a smooth transition to pre-k and other needed services (following discharge from the Early ACCESS program) are being made and/or are being implemented so that lapses in needed services are almost certain to occur. — **1** ☐

- **Not Applicable.** No transition is anticipated within the next six months. This review does not apply. — **NA** ☐

Service Review 15: Effective Results

EFFECTIVE RESULTS: To what degree are the planned early intervention services and supports offered in the IFSP resulting in improved functioning and achievement of desired outcomes for the child and family?

Services are provided to achieve specific results and benefits for the child and family. Key results should include improved functioning, achievement of outcomes consistent with the goals and priorities of the family. The expectation of positive results applies to all children, regardless of skill or age. If intervention strategies and services are not producing these results, then strategies and services should be modified over time as experience is gained about what expectations are reasonable and what interventions actually work.

Determination of results requires that data be gathered and used to measure change from a baseline reference point for each intervention goal. Effectiveness may be assessed using a combination of indicators that include direct measures of change variables; achievement of developmental milestones; and perceptions of interveners, the child, and the family. Results should be measured at frequencies consistent with the types of interventions being used and the rates of change expected in the child and family's goals. Knowledge of results should be used to determine what works for a child and/or family, to evaluate the course and pace of change, and to verify that important outcomes are being attained for the child and family.

Determine from Informants, Plans, and Records	Facts Used in Rating Performance
1. Are supports and services producing desired results and leading to attainment of important outcomes for the child and family? If not, what are the reasons? What is Early ACCESS doing to improve the situation?	
2. Have specific outcomes or results been targeted and achieved? If not, what are the reasons?	
3. Are noticeable changes occurring in the status of the child or family? Are these changes in the desired direction of improvement? If not, what is being done about it?	
4. What services are working or not working for this child and family? How is knowledge of results being used to plan new or ongoing services?	

Service Review 15: Effective Results

Description and Rating of Service System Performance

Description of the System Performance Situation Observed for the Child and Family — Rating Level

- **Optimal Service Results.** The strategies, supports, and services planned and delivered to the child and family are significantly improving/maintaining their functioning and producing excellent results. Changes from beginning measures of status and performance are used to track the course and rate of progress made. The child has been making progress at or above expectation for at least six months (or since implementation of services if less than six months have passed since admission). The service team continuously learns which things work and do not work for this child and family and plans new or ongoing services on the basis of needs and results. **6** ☐

- **Good Service Results.** The strategies, supports, and services planned and delivered to the child and family are substantially improving/maintaining their functioning and producing good results. Changes from beginning measures of status and performance are used to track the course and rate of progress made. The child has been making progress at or near expectation for at least three months. The service team frequently determines which things are working for this child and family. **5** ☐

- **Fair Service Results.** The strategies, supports, and services planned and delivered to the child and family are minimally improving/maintaining their functioning and producing fair results. Changes from beginning measures of status and performance are used to track the course and rate of progress made. The child is showing recent progress at or near expectation. The service team is attempting to determine which things are working and not working for this child and family. **4** ☐

- **Marginal Service Results.** The strategies, supports, and services planned and delivered to the child and family are limited or inconsistent in improving/maintaining their functioning and producing mixed results. Changes from beginning measures of status and performance may not be used to track the course and rate of progress made. The child is showing recent progress somewhat below expectation. The service team is uncertain about which things are working and not working for this child and family. Risk of poor outcomes seems presently low. **3** ☐

- **Poor Service Results.** Strategies, supports, and services may not be adequately planned or delivered to the child and family. They are not improving or maintaining their functioning. Service results may be poor. Beginning and progress measures may be inaccurate, limited, or missing. The child may be showing progress well below expectation. The service team may not be functioning well enough to explore which things are working and not working for this child and family. Risk of poor outcomes may be moderate and/or increasing. **2** ☐

- **Unknown, Absent, or Adverse Service Results.** Strategies, supports, and services may be limited, undependable, missing or conflicting for the child and family. They may be declining in their functioning. Service results are either unknown or unattained. Beginning and progress measures may be inaccurate, limited, or missing. The child may be regressing in some areas. The service team may not be functioning. Risk of harm or poor outcomes may be substantial. **1** ☐

SECTION 5

OVERALL PATTERNS

Overall Patterns of Interest **Page**

Overall Child and Family Status Scoring Procedure

There are 11 child and family status indicators to be conducted in the areas of Child and Family Status. Each review produces a finding reported on a 6-point rating scale. An "overall rating" for each section is based on THE REVIEWER'S HOLISTIC IMPRESSION OF THE APPLICABLE INDICATORS.

The reviewer must consider the unique issues and context for THIS CHILD & FAMILY to arrive at the overall status rating. (1) Begin by transferring the rating value for each status review item from the protocol review indicator pages to the summation tables below [or, better yet, to the "roll-up sheet" being prepared for submission]. (2) Disregard any indicators deemed not applicable in forming the holistic impression. (3) Give weight to those items judged to be most important at this time for this child and family. (4) Focusing on those applicable indicators giving them the greatest importance to the child and parent/caregiver at this time, determine an "overall rating" based on your general impression of the child's status and the parent's status and/or substitute caregiver's status. (5) Mark the boxes indicating your overall rating below. Report this rating value on the roll-up sheet prepared for this child and parent/caregiver.

Child & Family Status Indicators

Status Indicators	Improve		Refine		Maintain		NA
Current Life Situation	1	2	3	4	5	6	
1. **Safety of the child**							
a. Birth home	☐	☐	☐	☐	☐	☐	☐
b. Substitute home	☐	☐	☐	☐	☐	☐	☐
c. Child care settings	☐	☐	☐	☐	☐	☐	☐
2. **Physical well-being**							
a. Birth home	☐	☐	☐	☐	☐	☐	☐
b. Substitute home	☐	☐	☐	☐	☐	☐	☐
3. **Stability**	☐	☐	☐	☐	☐	☐	
4. **Permanency**	☐	☐	☐	☐	☐	☐	☐
5. **Daily setting**	☐	☐	☐	☐	☐	☐	
Development & Well-being							
6. **Development**	☐	☐	☐	☐	☐	☐	
7. **Health**	☐	☐	☐	☐	☐	☐	
8. **Social/Emotional/Behavioral**	☐	☐	☐	☐	☐	☐	
Parenting & Caregiving							
9. **Parenting/Caregiving**							
a. Birth parent	☐	☐	☐	☐	☐	☐	☐
b. Substitute caregiver	☐	☐	☐	☐	☐	☐	☐
10. **Parent/Caregiver participation**							
a. Birth parent	☐	☐	☐	☐	☐	☐	☐
b. Substitute caregiver	☐	☐	☐	☐	☐	☐	☐
11. **Parent/Caregiver satisfaction**							
a. Birth parent	☐	☐	☐	☐	☐	☐	☐
b. Substitute caregiver	☐	☐	☐	☐	☐	☐	☐
12. Overall Child Status	☐	☐	☐	☐	☐	☐	

Overall Recent Progress Scoring Procedure

There are four reviews to be conducted in the area of Recent Progress. Each review produces a finding reported on a 6-point rating scale. An "overall rating" of Recent Progress is based on THE REVIEWER'S HOLISTIC IMPRESSION OF THE CHILD'S OR CAREGIVER'S RECENT CHANGES ON APPLICABLE INDICATORS. (1) Begin by transferring the rating value for each progress review item from the protocol exam pages to the summation table below [or, better yet, to the "roll-up sheet" being prepared for submission]. (2) Disregard any indicators deemed not applicable in forming the holistic impression. (3) Give weight to those items judged to be most important at this time for this child and family. (4) Focusing on those applicable indicators giving them the greatest importance to the child and family at this time, determine an "overall rating" based on your general impression of the child and family's progress. (5) Mark the box indicating your overall rating below. Report this rating value on the roll-up sheet prepared for this child and family.

Recent Progress Pattern

Status Review Indicator	Improve		Refine		Maint.		NA
CHANGE OVER TIME	**1**	**2**	**3**	**4**	**5**	**6**	
1. Improved child functioning	☐	☐	☐	☐	☐	☐	
2. Enhanced caregiver capacity							
a. birth parent	☐	☐	☐	☐	☐	☐	☐
b. substitute caregiver	☐	☐	☐	☐	☐	☐	☐
3. Improved family participation in community							
a. birth parent	☐	☐	☐	☐	☐	☐	☐
b. substitute caregiver	☐	☐	☐	☐	☐	☐	☐
4. Progress toward IFSP outcomes	☐	☐	☐	☐	☐	☐	
5. OVERALL PROGRESS PATTERN	☐	☐	☐	☐	☐	☐	

Overall System/Practice Performance Scoring Procedure

There are 15indicators in the area of Current System Performance . Each review produces a finding reported on a 6-point rating scale. An "overall rating" of practice performance is based on THE REVIEWER'S HOLISTIC IMPRESSION OF ALL APPLICABLE INDICATORS ON THE APPROPRIATE EXECUTION OF PRACTICE FUNCTIONS AND THE DILIGENCE IT SHOWS IN RESPONSE TO THIS CHILD AND FAMILY. Consider the fidelity with which each practice function is carried out and whether the intent of the function is being achieved. Overall, is the system taking the necessary actions to appropriately address the individual factors for this child and family that must be addressed if this child and family are to make progress toward positive outcomes? (1) Begin by transferring the rating value for each progress review item from the protocol exam pages to the summation table below [or, better yet, to the "roll-up sheet" being prepared for submission]. (2) Disregard any indicators deemed not applicable in forming the holistic impression. (3) Give weight to those items judged to be most important at this time for this child and family. (4) Focusing on those applicable indicators having the greatest importance to the child and family at this time, determine an "overall rating" based on your general impression of the practice performance. (5) Mark the box indicating your OVERALL PRACTICE PERFORMANCE rating below. Report this rating value on the roll-up sheet prepared for this child and family.

System/Practice Performance

Performance Indicator Zones	Improve		Refine		Maintain		NA
Core Practice Functions	1	2	3	4	5	6	
1. **Family engagement**							
a. Birth family	☐	☐	☐	☐	☐	☐	☐
b. Substitute caregiver	☐	☐	☐	☐	☐	☐	☐
c. Service coordinator	☐	☐	☐	☐	☐	☐	
2. **Service team formation**	☐	☐	☐	☐	☐	☐	
3. **Service team functioning**	☐	☐	☐	☐	☐	☐	
4. **Evaluation, assess., underst.**	☐	☐	☐	☐	☐	☐	
5. **IFSP planning**	☐	☐	☐	☐	☐	☐	
6. **IFSP implementation**	☐	☐	☐	☐	☐	☐	
7. **Service coordination**	☐	☐	☐	☐	☐	☐	
8. **Monitoring, evaluation, modifi.**	☐	☐	☐	☐	☐	☐	
Practice Attributes							
9. **Family centered practice**	☐	☐	☐	☐	☐	☐	
10. **Cultural accommodations**	☐	☐	☐	☐	☐	☐	☐
11. **Resource availability**	☐	☐	☐	☐	☐	☐	
12. **Urgent response capability**	☐	☐	☐	☐	☐	☐	☐
13. **Family support & training**	☐	☐	☐	☐	☐	☐	
14. **Transition process**	☐	☐	☐	☐	☐	☐	☐
15. **Effective results**	☐	☐	☐	☐	☐	☐	
16. Overall Practice Performance	☐	☐	☐	☐	☐	☐	

Six-Month Prognosis for the Child and Family

ESTIMATING THE TRAJECTORY OF THIS CHILD'S EXPECTED COURSE OF CHANGE

Determination of current child status and service system performance is based on the observed current patterns as they emerge from the recent past. This method provides a factual basis for determination of current child status and service system performance. Forming a six-month prognosis or forecast is based on predictable future events and informed predictions about the expected course of change over the next six months, grounded on known current status and system performance as well as knowledge of tendency patterns found in case history.

Suppose that the child being reviewed has demonstrated a pattern of serious, complex, and recurrent health problems that were just being brought under control in April [Overall Child Status = 4, meaning child status is minimally and temporarily acceptable; a fact]. Suppose that this child had a relapse last summer [a fact] while away during the summer [a fact] and inadequate supervision in the home [a fact]. Suppose this child is to be discharged from the hospital at the end of June [a fact], but has no transition plan for returning to home and daycare [a fact], no planned health monitoring to keep the child out of trouble [a fact], continuing problems at home [a fact], and no contact or planning with the neighborhood school expected to admit and serve the child with 3-5 year old special education services when school begins in August [a fact]. Based on what is now known about this child, what is the probability that the child's status in six months (October) will: (1) Improve from a 4 to a higher level? (2) Stay about the same at level 4? or (3) Decline or deteriorate to a level lower than 4? Given this set of case facts plus the child and caregiver's tendency patterns described in recent history, most reviewers would make an informed prediction that the case trajectory would be downward and that the child's status is likely to decline or deteriorate. One may "hope" for a different trajectory and a more optimistic situation, but "hope " is not a strategy to change the conditions that are likely to cause a decline. Based on the reviewer's six-month prognosis or forecast for a case, the reviewer offers practical "next step" recommendations to alter an expected decline or to maintain a currently favorable situation over the next six months.

Based on what is known about this case and what is likely to occur in the near-term future, make an informed prediction of the six-month prognosis in this case. Mark the appropriate alternative future statement in the space provided below. The facts that lead the reviewer to this view of case trajectory should be reflected in the reviewer's recommendations. Insert your determination in the appropriate space on the roll-up sheet.

Six-Month Prognosis

Based on the child's current status on key indicators, recent progress, the current level of service system performance, and events expected to occur over the next six months, is this child's status expected to improve, remain about the same, or decline or deteriorate in the next six months? (check only one)

☐ **Improve status**

☐ **Continue—status quo**

☐ **Decline/deteriorate**

SECTION 5

REPORTING OUTLINES & JOB AID

Report Outline of Interest **Page**

Oral Case Presentation Outline

1. Core Story of the Child and Family **3 minutes**

- Reason for early intervention and other services
- Major outcomes of the IFSP (What are we trying to do in this case?)
- Strengths and needs of the child and family
- Services provided by Early ACCESS and other agencies

2. Child and Family Status **3 minutes**

- Overall child and family status finding/rating
- Progress made
- Problems

Emphasize any accomplishments or concerns related to community living, life skills, health, and development.

3. System Practice and Performance **3 minutes**

- Overall system performance finding/rating
- What's working now in this case
- What's not working and why
- Six-month prognosis

Emphasize any accomplishments or concerns related to treatment, family support, prevention/early intervention, emergent/urgent response, coordination of services.

4. Next Three Steps **1 minute**

- Recommended important and doable "next steps"
- Any special concerns or follow-up indicated

Total Presentation Time **10 minutes**

Group Questioning of Presenter **3-5 minutes**

Written Case Summary Outline

Child/Family Status Summary

Describe the child/family situation using a concise narrative form, mentioning historical facts that are necessary for understanding the current status. The following outline should be used to guide the narrative.

1. **Facts About the Child and Family.** [About 100 words]

   This section should provide a brief overview of the child and family, noting such key pieces of information as:

   - Family composition and situation
   - Child age upon entry into Early ACCESS
   - Reasons for early intervention services
   - Other agencies involved with the child and family

2. **Child's Current Status**. [About 250 words]

   Describe the current status of the child and family using the exam findings as a basis. If any unfavorable status result put the child at risk of harm, explain the situation. Mention relevant historical facts that are necessary for an understanding of the child and family's current status. Use a flowing narrative to tell the "story" and make sure that the "story" supports and adequately illuminates the Overall Status Rating.

3. **Family's Status**. [About 100 words]

   Because the status of the child often is linked to the status of the family, indicate whether the family is receiving the supports necessary to adequately meet the needs of the child and maintain the integrity of the home.

4. **Factors Contributing to Favorable Status**. [About 100 words]

   Where status is positive, indicate the contributions that child resiliency, family capacities, and uses of natural supports and generic community services made to the results.

5. **Factors Contributing to Unfavorable Status**. [About 100 words]

   When status is mixed or unacceptable, indicate what factors seem to be contributing to current status and how the child may be adversely affected now or in the near-term future, if status is not improved.

System Performance Appraisal Summary

Describe the current performance of the service system for this child and family using a concise narrative form. Mention any historical facts or local circumstances that are necessary for understanding the situation. The following outline should be used to guide the narrative.

6. **What's Working Now**. [About 250 words]

   Identify and describe which service system functions are now working adequately for this child and family. Briefly explain the factors that are contributing to the current success of these system functions.

7. **What's Not Working Now and Why**. [About 150 words]

   Identify and describe any service system functions that are <u>not</u> working adequately for this child and family. Briefly explain the problems that appear to be related to the current failure of these functions.

8. **Six-Month Prognosis/Stability of Findings**. [About 75 words]

   Based on current service system performance found for this child, is the child's Overall Status likely to improve, stay about the same, or decline over the next six months? Take into account any important transitions that are likely to occur over this time period. Explain your answer.

9. **Practical Steps to Sustain Success and Overcome Current Problems**. [About 75 words]

   Suggest practical steps that should be taken to sustain and improve successful service system functions over the next six months. Suggest practical steps that should be taken to overcome current problems and to improve poor service system functions, if any, so that they will work adequately for this child and family within the next 90 days.

The summary should not exceed two-to-three typed pages, depending on the complexity of the case and the extent of supports and services being provided by various agencies.

Job Aid for Indicators of Quality Caregiving

The items in this job aid provide reviewers involved in the Early ACCESS Quality Service Review with information about quality indicators of infant-toddler caregiving. It is intended to provide reviewers with best practice knowledge as they address the following protocols: Parenting/Caregiving; Daily Settings/Environments; and Safety.

The items are organized into five broad categories: (I.) Quality of Caregivers' Interaction with Infants, (II.) Family Partnerships, Cultural Responsiveness, and Inclusion of Children with Disabilities and Other Special Needs, (III.) Relationship-Based Care, (IV.) Physical Environment and (V.) Routines and Record Keeping.

These items are from the Program Assessment Rating Scale (PARS), an assessment used in the Iowa Program for Infant-Toddler Caregivers, and is a product of the Program for Infant & Toddler Caregivers, which was developed by WestEd and the CA Department of Education. Reprinted with permission.

For reviewers that wish to see the alignment of PARS with the Early ACCESS QSR protocols, the following chart provides a cross walk.

PARS Sections	QSR Protocol
I. Quality of Caregivers' Interaction with Infants	Parenting/Caregiving, Physical Well-being
II. Family Partnerships, Cultural Responsiveness, and Inclusion of Children with Disabilities and Other Special Needs	Parenting/Caregiving, Daily Settings, Cultural Accommodations
III. Relationship-Based Care	Parenting/Caregiving
IV. Physical Environment	Safety, Daily Settings
V. Routines and Record Keeping	Parenting/Caregiving, Daily Settings

PARS

I. Quality of Caregivers' Interaction with Infants

A. Responsiveness and Sensitivity to Children

1. The caregiver responds promptly and appropriately to infants' non-distressed cues such as vocalizations, gestures, requests, moods, and other nonverbal and verbal cues.

2. The caregiver consistently acknowledges when a child is interested in social interaction such as mirroring or imitating a smile, making eye contact when the child attempts to make eye contact, or making a comment when the child gives or shows something.

3. The caregiver responds promptly to children's distress cues.

4. The caregiver tries to understand the child's distress or discomfort in a way that meets the child's need or comforts the child. When a child seeks comfort, cries, or expresses sadness, the caregiver responds consistently and attempts to meet the child's need or comforts the child. When a child expresses anger, the caregiver gently acknowledges the child's feelings and, if necessary, redirects her or his behavior.

B. Positive Tone and Attentiveness

1. The caregiver expresses a positive, warm tone with infants.

2. The caregiver emotionally and physically relates to children with gentleness. The caregiver uses a gentle and supportive voice when setting limits.

3. The caregiver does not engage in a lot of conversations with other adults.

4. The caregiver observes all the infants in care with interest and is emotionally and physically available to meet each child's needs for attention or support.

C. Responsive Engagement and Intervention

1. The caregiver initiates interaction with young infants when infants are alert and active. The caregiver regularly communicates with older infants to find out whether they would like to interact or engage in an activity.

2. The caregiver disengages when a child disengages—for example, if the child looks away or tries to avoid interacting with a caregiver, or appears tired and distracted. The caregiver stops trying to initiate interaction or an activity with a child if the child does not respond with interest.

3. The caregiver intervenes by gently guiding an infant if the infant starts to hurt another child. The caregiver intervenes at appropriate times to set limits and resolve conflicts between children 15 months or older.

4. The caregiver is playful with children while being careful to avoid over-stimulation.

D. Respect for Infants' Initiative and Choices

1. The caregiver follows children's lead, allowing infants and toddlers to choose activities and play materials

2. The caregiver does not expect young and mobile infants to join or stay in a group activity, and children are free to join, leave and rejoin the group. If the caregiver initiates group activities, it is in response to children's interests.

3. The caregiver avoids interrupting infants who are engaged in activity or exploring. If the caregiver has to interrupt a child to do a caregiving routine, the caregiver gives the child time to transition from the activity to the routine.

4. The caregiver is flexible and adapts to the children's ways of manipulating or exploring materials.

E. Facilitation of Cognitive Development and Learning

1. The caregiver seeks to expand learning when interacting with infants engaged in discovery or learning.

2. The caregiver avoids intervening in children's activities or interrupting them when they are concentrating on making a discovery or engaged in self-initiated learning.

3. The caregiver's responses reflect an understanding of the focus of the infants' learning, for example, cause-effect relations or the use of tools.

4. The caregiver acts in a way that allows children to be in control of the activity when helping infants solve a problem or make a discovery.

F. Facilitation of Language Development and Communication, Part I

1. The caregiver frequently talks with children at appropriate times and consistently gives the children opportunities and time to respond.

2a. The caregiver listens and watches young infants in order to imitate their sounds and nonverbal communication. Caregivers connect language with non-verbal gestures.

2b. The caregiver listens and adds to topics initiated by toddlers, encouraging give and take communication. The caregiver asks open-ended questions that invite children to give creative or expressive responses rather than yes/no or "correct answer" responses.

3. Caregivers use parallel talk, commenting on the children's focus of interest or activity.

4. Caregivers use self-talk, commenting on their own actions.

G. Facilitation of Language Development and Communication, Part I

1. The caregiver makes available a variety of books, allows free exploration of books, encourages children's exploration of books, looks at books with children, and reads and tells stories.

2 The caregiver offers opportunities for playfulness with language. For example, finger play, songs, puppets, and socio-dramatic play

3. The caregiver accepts children's expression of language and communication without correcting them.

4. The caregiver uses child-directed language.

II. Family Partnerships, Cultural Responsiveness, and Inclusion of Children with Disabilities and Other Special Needs

A. Relationships with Families

1. The program emphasizes developing a partnership with the family. The program's written and oral communication with the family promotes the development of a partnership.

2. The program's philosophy statement or handbook recognizes the importance of connecting the infant's experience at home with the child care setting.

3. The program seeks family input regarding policy issues.

4. Families are always welcome to visit.

B. Communication with Families

1. Program staff regularly communicate with families about their children to share what is happening in care and find out what the children are experiencing at home. The primary caregiver is regularly available for one-on-one meetings as needed.

2. There is an area with information posted for families.

3. The program shares children's records with families, including assessment information on children's learning, experiences and developmental progress.

4. The program has regularly scheduled meetings for families to learn more about the program and to build a sense of community within the program.

C. Culturally Responsive Care

1. The program's philosophy statement or handbook

recognizes the importance of connecting the children's cultural or linguistic experience at home to child care.

2. Specific practices are in place that help the program provide culturally consistent care. For example, questions on the intake form focus on cultural preferences and practices.

3. The child care environment reflects the children's cultural experiences.

4. Program staff is supportive of a family's cultural style and responds positively to the child's expressions of cultural identity.

D. Representative Staffing

1. Outreach efforts to achieve representative staffing are explained in a written policy and pertain to all staffing levels within the program.

2. Volunteers from the children's cultural and linguistic community are given roles in the program that allow them to interact with the children directly.

3. Families' input is sought when identifying and hiring new staff.

4. Either the staff is representative of the children's cultural and linguistic community, or the program actively engages in outreach to find representative staff.

E. Inclusion of Children with Disabilities and Other Special Needs

1. The program has a written policy for complying with the Americans with Disabilities Act and its implications for infant/toddler care.

2. The policy for compliance is included in the program's parent handbook.

3. The program is serving children with disabilities and other special needs, or the program (1) participates in efforts that encourage the enrollment of children with disabilities and other special needs and (2) engages in recruitment of children with disabilities and other special needs.

4. The program staff have received training on caring for children with disabilities and other special needs. If the program is serving children with disabilities and other special needs, it has made appropriate accommodations to meet the needs of the children and their families.

III. Relationship-Based Care

A. Primary Caregiving

1. One or two primary caregivers are assigned to cover each child's stay in child care. When the child's day is longer than the primary caregiver's day, a second primary caregiver is assigned. When there are two primary caregivers because of the length of the children's day in care, transition time is allotted to allow the caregivers to share information and concerns about the children. No more than two primary caregivers are assigned to cover the length of a child's day.

2. The primary caregiver(s) cares for the same children each day and carries out caregiving routines with them most of the time they are in care.

3. Team caregiving (two caregivers working in the same room, with each being primarily responsible for half the total group) and the regular sharing of information between caregivers about the children in their care ensures that each child will have a familiar caregiver when the primary caregiver is absent.

4. The primary caregiver(s) communicates with the child's parents and keeps records related to the child's development and care.

B. Continuity of Care

1. Center-based programs offer continuity to children through either same-age or mixed-age continuity. The program accommodates differing developmental levels and ages (i.e. adapts the environment and play materials as necessary).

2. The program has appropriate procedures in place

for transitioning children to a new caregiver if the child's current caregiver leaves the program.

3. The program has appropriate procedures for introducing a new child to an established group.

4. Staff have professional development opportunities to learn more about caring for young, mobile, and older children in order to support continuity of care.

C. Following Children's Individual Schedules

1. Individual schedules for feeding are followed for children aged birth to two. Meal times may be established for two-year-olds in the group, but children at that age who prefer to follow their own schedules are allowed to do so. Caregivers handle the schedule for older infants flexibly to accommodate individual differences. Individual older infants are consistently allowed to choose when to follow the group feeding schedule.

2. Individual schedules for napping are followed for children aged birth to two. Caregivers handle the schedule for older infants flexibly to accommodate individual differences. Nap times may be established for two-year-olds in the group, but children at that age who prefer to follow their own schedules are allowed to do so. Children at the beginning of the older infancy period (often 18 to 24 months) who prefer to adjust their schedules to the nap times established for two year olds in the group are allowed to do so.

3. Individual schedules for diapering are followed for children.

4. The children consistently have several activity or play choices available to them. When group times occur for older infants, the group activity is usually spontaneous in response to the children's interests, and children are free to join, leave and rejoin the group. Young and mobile infants are not expected to join or stay in a group activity.

D. Group Size and Structure

1. Children are cared for with an age appropriate caregiver: child ratio. The program adheres to the following PITC caregiver:child ratio guidelines:

Same-Age Groups

Age	Ratio
Birth – 18 months	1:3
18 – 36 months	1:4

Mixed-Age Groups

Age	Ratio
Birth – 36+ months	1:4*

** Of the four infants assigned to a caregiver, only two should be under twenty-four months of age.*

2. Children are divided into small groups. Each group remains separate from all other small groups throughout the day by either being in a separate room or in a space defined by dividers that are at least three feet high in a larger room. The program adheres to the following PITC group size guidelines:

Same-Age Groups

Age	Total Group Size
Birth – 8 months	6
8 – 18 months	9
18 – 36+ months	12

Mixed-Age Groups

Age	Total Group Size
Birth – 36+ months	8

3. The program meets or exceeds the following PITC recommendations for the amount of square footage for the group:

4. Small groups do not come together in common areas for more than 15 minutes a day during activities such as outside play time or arrival/departure.

IV. Physical Environment

A. Room Arrangement

1. The room is clearly organized into separate activity and caregiving routine areas. If necessary for children 12 months or older, it is appropriate to put cots or mats in the eating area during naptime. The napping and diaper areas are separate from each other.

2. The room is arranged with an open area that allows easy access to all activity areas.

3. The room arrangement facilitates adult supervision of all areas.

4. Traffic patterns do not interfere with the children's activity areas. Areas that support quiet activity, such as looking at books, are sheltered from other areas, both indoors and outdoors. There is a protected infant area both indoors and outdoors.

B. Opportunities for Exploration

1. The indoor environment offers a rich variety of activity choices, including small and large muscle activity, fantasy play, block play, and quiet exploration of books or other materials.

2. The outdoor environment offers a rich variety of activity choices, including small and large muscle activity, fantasy play, and quiet exploration of books or other materials.

3. There are enough materials for several children to engage in a similar activity both indoors and outdoors.

4. Similar materials are placed together in activity areas to encourage children to explore a specific interest they may have.

C. Opportunities for Movement

1. Children have age-appropriate opportunities to move freely indoors.

2. Children have age-appropriate opportunities to move freely outdoors.

3. The environment allows the children to move freely between indoor and outdoor areas during times of day when children have access to outdoor areas.

4. The environment, both indoors and outdoors, allows for vertical movement, such as climbing, so that children may practice physical skills and see things from different perspectives.

D. Safety of Play Materials and Environment

1. The indoor areas available to the children are completely safe and easy to supervise.

2. The outdoor areas available to the children are completely safe and easy to supervise.

3. Climbing equipment and slides are appropriate heights for the ages of children in the group. Soft surfaces underneath climbing structures meet appropriate safety standards for cushioning falls.

4. Emergency drills are practiced with children monthly to ensure emergency preparedness. New staff members and parents are made aware of emergency procedures.

E. Cleanliness of Play Materials and Environment

1. Floors and surfaces are cleaned and maintained as needed.

2. Floors and surfaces are cleaned and disinfected daily.

3. Toys and equipment are washed and disinfected at least once daily. Toys are immersed and washed in soapy water and then disinfected in a bleach solution daily.

4. Toys mouthed by an infant are removed after the infant has lost interest and are returned to the play area only after the item or items are washed and disinfected. Toys used by older infants are washed and disinfected as needed.

F. Comfort of Infants and Adults

1. Furnishings are child-sized and appropriate for the ages of the children in the room.

2. There are several "cozy" areas inside the room.

3. Adult furnishings allow caregivers to sit comfortably at the children's eye level.

4. Each separate play area comfortably accommodates two to three children and one adult.

G. Reduced Stimulation

1. The room has a variety of fabric and other sound absorption materials to reduce noise.

2. Soft colors that create a sense of calm are present throughout the children's play areas.

3. There is a moderate amount of play materials, which gives the children a good array of choice but does not overwhelm them.

4. Music is not played constantly. Music is appropriately played at the times when children show interest.

V. Routines and Record Keeping

A. Healthful and Safe Feeding Routines

1. Caregivers follow sanitary practices and wash hands thoroughly before and after handling food. Caregivers ask children to wash their hands before they feed themselves or eat, or, if they are too young to wash their hands, caregivers help children wash their hands.

2. Caregivers sit with children during feeding and mealtimes (holding young infants, sitting at a small table with mobile and older infants). Infants are held for bottle feedings. Mobile infants may drink from bottles on their own with their heads propped on a pillow and a caregiver nearby. Children are not put in bed with bottles nor are they allowed to walk or run around the setting with bottles.

3. When meals are provided by the program, children are given age-appropriate food such as mother's milk or formula for young infants; a variety of pureed and soft finger food for mobile infants, introduced one at a time; or a balance of foods from the five main food groups served in small pieces for older infants.

4. The eating or feeding area is peaceful and attractive, with easy-to-clean washable surfaces and floors. These areas are washed and disinfected before and after snack or meal times.

B. Healthful and Safe Diapering and Toileting*
** If all the children in the group already use the toilet, only rate items 1b-4b.*

1. Caregivers wash their hands before and after diapering or toileting. Gloves are not required unless there is blood in the diaper or the caregiver has open cuts on her or his hands. If gloves are used, the caregiver removes and disposes of the gloves appropriately.

1b. Caregivers either have children wash hands after toileting or assist them.

2. After the dirty diaper and soiled clothing have been removed and the child's bottom has been cleaned, the dirty diaper, used wipes or washcloth, disposable sheeting and, as needed, gloves are discarded before the clean diaper is put on the child.

2b. If children need help with cleaning bottom after toileting, caregivers should use gloves, discard the gloves in a plastic-lined, foot-operated trash can, and then wash their hands.

3. All dirty and used items during a diaper change are disposed of in a plastic-lined, foot-operated trash can.

3b. Children are supervised when using the toilet to make sure they are safe and clean themselves appropriately.

4. After each diaper change is complete and the child is no longer in the area, the changing surface is cleaned and disinfected with a bleach solution spray and left to air dry.

4b. Children are not encouraged to use the toilet until they indicate a readiness to do so.

C. Healthful and Safe Napping

1. Cots, cribs and bedding are cleaned and disinfected weekly or as needed.

2. Nap items for each child are stored individually in cubbies, baskets, or bins in a way that they do not touch one another.

3. Cots and cribs are placed no closer than three feet apart unless children sleep head to foot, in which case the cots and cribs can be no less than 18 inches apart from one another.

4. Caregivers monitor napping children of all ages to make sure they are safe and sleeping comfortably. Infants under six months old or who cannot easily turn over on their own are placed on their backs in cribs to lower the risk of SIDS.

D. Record Keeping and Information Sharing

1. A developmental assessment is made shortly after enrollment and updated throughout the child's attendance in the program.

2. A daily log is used to record notable events of each child's day, and a daily communication system specifically informs parents about their child's feeding/eating, diapering/toileting, and nap routines.

3. A file is maintained for each child with information on the child's social-emotional, physical, cognitive, and language development based on caregivers' observations, information from the family, up-to-date immunization cards, and for infants under one year of age, the physician's report and an Infant Meal Plan.

4. The program informs parents when children have been exposed to communicable diseases.

SECTION 6

GENERAL INFORMATION

Topic Areas **Page**

General Information

Child's Name, Last name first	Date of Birth	Age in Months	Child's Gender
	___/ ___/ ___		☐ Boy ☐ Girl

Child's Ethnicity as Indicated on IFSP

☐ Native Indian or Alaskan Native ☐ Black - Not of Hispanic origin ☐ Asian or Pacific Islander ☐ Hispanic
☐ White - Not of Hispanic origin

Child's Home and Primary Caregiver

Primary Home Caregiver's Name(s) and Relationship

Child's Current Home Address and Phone Number

Address:

Phone:

Relationship to child:

Child's Child Care Provider

Primary Child Care Porvider's Name

Child's Current Child Care Address and Phone Number, if different from home

Address:

Phone:

Relationship to child:

Child's Current Living Situation

☐ Birth family home
☐ Adoptive family home
☐ Kinship care arrangement (child welfare)
☐ Shelter
☐ Foster home
☐ Hospital/NICU
☐ Child/family living in home of relatives or friends
☐ Other: _____

Notes/Comments

Professionals Supporting the Child & Family

	Name	Role	Agency Affiliation	Member of Service Team
1.		Service coordinator		☐
2.				☐
3.				☐
4.				☐
5.				☐
6.				☐
7.				☐
8.				☐

Child's Early Identification and Intervention Service Sequence

Child's Early Indentification History

EARLY IDENTIFICATION: Was child referred to Early ACCESS upon first detection of a qualifying condition in order to maximize the benefit of early intervention services in this child's development?

☐ **YES** ☐ **NO**

Early, the first word of the Early ACCESS system's name, means connection of children and families to needed services as soon as possible. Early experiences affect the development of the child's brain. Both genetic and environment influences work together to shape a child's life, so they are both sources of human potential and growth as well as risk and dysfunction. Early intervention services are meant to promote children's health and development and minimize the potential for health risks and developmental delays. Research convincingly substantiates that the earlier children with special needs receive appropriate services, the better the developmental outcomes achieved. Children's early development is influenced by the health and well- being of their parents. No one agency is able to provide the wide range of informal and formal, typical and specialized resources and services that families need. Early connection of families to the interagency, coordinated Early ACCESS system will enhance their access to needed resources and supports. Community providers such as physicians and newborn health and child care professionals are important referral sources. These professionals need routine access to appropriate information about: (1) the availability, purpose, and services of the Early ACCESS system; (2) appropriate screening tools and procedures; and (3) detailed referral procedures including confidentiality. Knowledge and use of this information are critical to connecting children as early as possible to the Early ACCESS system.

Timeliness of Detection, Referral, Eligibility, Service Provision	Findings from Record Reviews and Interviews
1. On what specific condition was this child determined eligible for early intervention services via the Early ACCESS system?	1. Eligible condition: _____
2. At what age and by whom (title/role/agency affiliation) was this condition of eligibility first identified?	2. Child's age in months: _____ months of age Person identifying condition: _____
3. At what age and by whom (title/role/agency affiliation) was this child first referred to the Early ACCESS system for evaluation and eligibility determination?	3. Child's age in months: _____ months of age Person making referral: _____
4. How many days elapsed between first identification and subsequent referral to the Early ACCESS system?	4. Time-lapse in days: _____ days of time elapsed
5. How many days elapsed between referral and eligibility determination?	5. Time-lapse in days: _____ days between referral and eligibility determination
6. Was the 45-day timeline met? If not, were the reasons for the time delay documented?	6. 45-day timeline met: ☐ YES ☐ NO ☐ UNKNOWN Documented reasons for delay: _____
7. If delay in excess of 45 days did occur, to what causes do the parents attribute the delay?	7. Delay noted: ☐ YES ☐ NO Parent's reasons: _____
8. If delay in excess of 45 days did occur, to what causes does the service coordinator attribute the delay?	8. Delay noted: ☐ YES ☐ NO Serv. coord. reasons: _____
9. How many days elapsed between determination of eligibility and the actual provision of early intervention services provided via the Early ACCESS system?	9. Time-lapse in days: _____ days between eligibility and actual receipt of services

Timeline Observed for this Child: Indentification to Referral to Eligibility to Receipt of Services *(Mark Chart Below)*

Timeline in Months

Birth..1...2...3...4...5...6...7...8...9...10..11..12..|..13..14..15..16..17..18..19..20..21..22..23..24..|..25..26..27..28..29..30..31..32..33..34..35..36..**Transition**

First year of life | **Second year of life** | **Third year of life**

Use this timeline to mark age at detection, referral, eligibility, and first receipt of services and to note time elapsed between each event.

Child's Current Eligibility Status

The purpose of this page is to document reasons for eligibility. Complete **EITHER** Developmental Delay **OR** Condition, based on the child's most recent eligibility determination.

DEVELOPMENTAL DELAY, which is a 25 percent delay as measured by appropriate diagnostic instruments and procedures and based on informed clinical opinion, in one or more of the follow developmental areas:

Types of Delays	At Least 25% Delay	Within Normal Limits	Dates	Specialist	Medications Needed
Cognitive development	Yes No				Yes No
Physical development	Yes No				Yes No
Communication development	Yes No				Yes No
Social or emotional development	Yes No				Yes No
Adaptive development	Yes No				Yes No

CONDITION, based on informed clinical opinion, known to have a **HIGH PROBABILITY** of resulting in later delays in growth and development if early intervention services are not provided.

Examples of Conditions	Specific Condition Described	Specialized Treatment Needed	Dates	Specialist	Medications Needed
Chromosomal abnormalities including but not limited to: Down's syndrome, cystic fibrosis, fragile X, dwarfism, etc.					Yes No
Sensory impairments including but not limited to: vision and hearing deficits, etc.					Yes No
Inborn errors of metabolism including but not limited to: phenylketonuria and hypothyroidism, galactosemia, sickle cell disease, etc.					Yes No
Congenital central nervous disorders including but not limited to: spina bifida, microcephaly, seizure disorders, etc.					Yes No
Other congenital or acquired conditions including but not limited to: cleft palate, missing limbs, cerebral palsy, traumatic brain injury, physical impairments from birth or accident, etc.					Yes No
Venous blood lead level greater than or equal to 20 micrograms per deciliter.					Yes No
Other conditions resulting form serious chronic illness, fetal drug or alcohol exposure, failure to thrive, serious attachment disorders, low birth weight or prematurity.					Yes No
Atypical functional and behavioral issues including: pervasive development disorder (PDD) and autism.					Yes No

Note: See Early ACCESS eligibility guidelines

General Family Information

Applies to the bio-family home (for a child living at home or returning to the family home) or to an adoptive family home.

If parental rights are terminated and no adoptive family has been designated, leave blank.

☐ Family home ☐ Adoptive home

Adult(s) over 18 Name:	Relationship to Family	Age	Gender	Race
Adult 1			☐ M ☐ F	
Adult 2			☐ M ☐ F	
Adult 3			☐ M ☐ F	
Adult 4			☐ M ☐ F	

Adult(s) living outside home (e.g., divorced parent, no contact orders, etc.)	Relationship to Family	Age	Gender	Race
Adult 1			☐ M ☐ F	
Adult 2			☐ M ☐ F	

Children's Names:	Age	Gender	Race	Out-of-Home Placement
Child 1		☐ Boy ☐ Girl		☐ Yes
Child 2		☐ Boy ☐ Girl		☐ Yes
Child 3		☐ Boy ☐ Girl		☐ Yes
Child 4		☐ Boy ☐ Girl		☐ Yes
Child 5		☐ Boy ☐ Girl		☐ Yes
Child 6		☐ Boy ☐ Girl		☐ Yes

Please list any special needs of the parents/caregivers that would be helpful for the reviewers.

Notes/Comments

Services and Supports for the Family

	Type of Service	Formal		Informal
		Needed/Received	Needed/Not Received	Received
1.	Family services to build support network	☐	☐	☐
2.	Respite care services	☐	☐	☐
3.	Wraparound services	☐	☐	☐
4.	Assistive technology services	☐	☐	☐
5.	Audiology services	☐	☐	☐
6.	Family training, counseling and home visits	☐	☐	☐
7.	Health services	☐	☐	☐
8.	Medical services only for diagnostic or evaluation purposes	☐	☐	☐
9.	Nursing services	☐	☐	☐
10.	Nutrition services	☐	☐	☐
11.	Occupational therapy	☐	☐	☐
12.	Physical therapy	☐	☐	☐
13.	Psychological services	☐	☐	☐
14.	Social work services	☐	☐	☐
15.	Special instruction	☐	☐	☐
16.	Speech-language services	☐	☐	☐
17.	Diagnosis and assessment	☐	☐	☐
18.	Hospital/NICU	☐	☐	☐
19.	High risk follow-up	☐	☐	☐
20.	Transportation and other related costs	☐	☐	☐
21.	Transition services	☐	☐	☐
22.	Other:	☐	☐	☐
23.	Other:	☐	☐	☐
24.	Other:	☐	☐	☐

Notes/Comments

Reviewer's Assessment of the Child and Family's Circumstances

	Capable family with typical strengths and needs	Stressed family with short-term or low level needs in one or two areas	Challenged family with major needs in one or two areas	Family with major needs which compromise child's safety and/or basic care
Child has major needs in more than one areas and/or has a disability and is regressing below expectations	3 Child with intensive needs in a capable family [HI RISK]	3 Child with intensive needs in a stressed family [HI RISK]	3 Child with intensive needs in challenged family [HI RISK]	3 Child w/ intensive needs in home w/ major needs or in foster care/unsafe home [HI RISK]
Child with major need in one need area or has a disability and is making progress but failing to meet expectations	2 Child with a major need in a capable family [MOD RISK]	2 Child with a major need in a stressed family [MOD RISK]	3 Child with major needs in a challenged family [HI RISK]	3 Child w/ a major need in home with major needs or in foster care/unsafe home [HI RISK]
Child with short-term or low level support needs, or has a disability and is functioning up to expectations	1 Child with low level needs in a capable family [LOW RISK]	1 Child with low level needs in a stressed family [LOW RISK]	2 Child with low level needs in a challenged family [MOD RISK]	2 Child w/ low level needs in home w/ major needs or in foster care* [MOD RISK]
Child having routine needs of a typical child or slight delay in one area	0 Typical child in a capable family (LOW RISK)	1 Typical child in a stressed family [LOW RISK]	2 Typical child in a challenged family [MOD RISK]	2 Typical child in home with major needs or in foster care* [MOD RISK]

Need Level Profile

- Low = 1
- Moderate = 2
- High = 3

** Raise to 3, if placement is inappropriate, inadequate, or at risk of disruption*

Capability of the Family

Need areas include housing, limited caregiver capacity, domestic violence, substance abuse, health insurance, poverty, single/teen parent, parent with no social support system, etc.

Instructions: Choose the most appropriate row describing level of child's special needs (see left side of matrix). Choose most appropriate column describing level of family capability (see bottom of matrix). This row and column meet in a single cell of the matrix. The level of need for that cell (LO, MOD, HI) is entered in #24 on the profile sheet.